OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

OFFICE OF ADMINISTRATIVE HEARINGS
FAX to: (518) 473-6735

FAIR HEARING REQUEST FORM – FAX OR MAIL
P.O. BOX 1930
ALBANY, NY 12201-1930
Please Print Information Clearly. Correct and Complete Information will Permit us to Promptly Schedule a Fair Hearing

CASE NAME: _____ _____ _____
(LAST) (FIRST) (MI)

STREET ADDRESS: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: ( ) _____ DATE OF BIRTH: _____ SS#: _____
AREA CODE PHONE #

☐ MALE ☐ FEMALE CASE #: _____ CIN #: _____ LOCAL AGENCY/CENTER #: _____

INTERPRETER NEEDED? ☐ YES ☐ NO LANGUAGE: _____

Is appellant homebound? ☐ **Yes** ☐ **No If yes, provide medical documentation. Do not delay request to obtain medical. A phone number for representative or requester is required if you don't have a phone:**

☐ **Representative** ☐ **Requester** NAME: _____

ADDRESS:
_____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE #: ( ) _____
AREA CODE PHONE #

DID APPELLANT RECEIVE A NOTICE FROM THE LOCAL SOCIAL SERVICES DEPARTMENT? YES NO
(*** PLEASE ATTACH A COPY OF THE NOTICE WITH THIS FORM *****)**

If Yes: Date of Notice: _____ Effective Date: _____ NOTICE #: _____ RTI #: _____

RESTRICTIONS
Put an X in days or times you cannot attend hearing

	M	T	W	T	F
AM	__	__	__	__	__
PM	__	__	__	__	__

LOCAL AGENCY ACTION **CATEGORY OF ASSISTANCE (definitions below box)**

	FA	SNA	MA	FS	FAP	PCS*	OTHER (indicate what type)
Discontinuance	☐	☐	☐	☐	☐	☐	☐ _____
Reduction	☐	☐	☐	☐	☐	☐	☐ _____
Denial	☐	☐	☐	☐	☐	☐	☐ _____
Inadequacy	☐	☐	☐	☐	☐	☐	☐ _____

* If Personal Care Services: Provide CASA # _____/Agency _____ & indicate type of services: _____

FA=Family Assistance (formerly ADC) SNA=Safety Net Assistance (formerly HR) MA=Medicaid
FS=Food Stamps FAP=Food Assistance Program PCS=Personal Care Services

Reason for requesting hearing (indicate time frames):
_____
_____
_____
_____
_____
_____
_____

TODAY'S DATE _____