OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
Website: www.otda.ny.gov/oah

OFFICE OF ADMINISTRATIVE HEARINGS
FAX to: (518) 473-6735
Telephone #: 1-800-342-3334

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#: ______________

☐ 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 while obtaining medical. A phone number for representative or requester is required if you don't have a phone.**

☐ **Representative** ☐ **Requester** NAME: ______________________

ADDRESS: ______________________

CITY: ______________________ STATE: _______ ZIP: ________ 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	___	___	___	___	___

(Must provide a reason)

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

	FA	SNA	MA	SNAP	HEAP	PCS*	OTHER	
Discontinuance	☐	☐	☐	☐		☐	☐	________
Reduction	☐	☐	☐	☐		☐	☐	________
Denial	☐	☐	☐	☐	☐	☐	☐	________
Inadequacy	☐	☐	☐	☐	☐	☐	☐	________

* If Personal Care Services: Provide CASA # _______/Agency ________ & indicate type of service: _______

Name of Managed Care Plan ______________________

FA = Family Assistance (former ADC)
SNA = Safety Net Assistance (formerly HR)
SNAP = Supplemental Nutrition Assistance Program (formerly Food Stamps)
MA = Medicaid
HEAP = Home Energy Assistance Program
PCS = Personal Care Services

Reason for requesting hearing (indicate time frames): ______________________

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Information needed for Foster Care hearings: Child's name, child's date of birth, birth mother's name, child's case number, agency's name. Indicate period seeking foster care payments.

TODAY'S DATE: ______________________