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

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#: _____

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):

_____

_____

_____

_____

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: _____

Revised 12/21/21