

FAIR HEARING REQUEST FORM
HOME AND COMMUNITY SERVICES WAIVER FOR INDIVIDUALS
WITH MENTAL RETARDATION

TO: DEPARTMENT OF PUBLIC WELFARE
BUREAU OF HEARINGS AND APPEALS
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-267512

FROM:

NAME OF INDIVIDUAL/LEGAL REPRESENTATIVE	DAY TELEPHONE NUMBER
MAILING ADDRESS	

DATE:

I HEREBY REQUEST A FAIR HEARING BEFORE THE DEPARTMENT OF PUBLIC WELFARE, BUREAU OF HEARINGS AND APPEALS. I AM REQUESTING THIS APPEAL ON BEHALF OF THE FOLLOWING INDIVIDUAL RECEIVING HOME AND COMMUNITY BASED SERVICES FUNDED UNDER A MEDICAID WAIVER FOR INDIVIDUALS WITH MENTAL RETARDATION.

NAME OF INDIVIDUAL RECEIVING SERVICES
ACCESS NUMBER OF INDIVIDUAL RECEIVING SERVICES

I HEREBY REQUEST THIS APPEAL BASED ON THE FOLLOWING ACTION(S)

(ATTACH ADDITIONAL INFORMATION IF NEEDED TO THIS FORM)

PLEASE CHECK ONE OF THE ITEMS BELOW TO INDICATE THE TYPE OF HEARING YOU WANT:

- I WANT A TELEPHONE HEARING
- I WANT A FACE TO FACE HEARING

PLEASE INDICATE BELOW WHAT TYPE OF INTERPRETER, COMMUNICATIONS ASSISTANCE OR ACCOMODATION YOU NEED, IF ANY, AT THE HEARING:

CC: COUNTY MENTAL HEALTH MENTAL RETARDATION PROGRAM
REGIONAL OFFICE OF MENTAL RETARDATION