TEXAS Health and Human Services

Form H4800
July 2009-E

Fair Hearing Request Summary

To: Hearing Division		Agency Representative's Name	Region	Unit No.
Date Sent to Hearings Office	Date Received by Hearings Office	Direct Dial Area Code and Telephone No. for Agency Representative		
Method Form H4800 Sent ☐ **Electronic Mail** ☐ **Fax** ☐ **Mail**		Agency Representative's Office (include Street Address, City, State, ZIP Code)		
Appellant's Name		Agency Representative's Email Address		
Case No.	EDG No. (TIERS cases only)	Supervisor's Name (as shown in Outlook)	Supervisor's Area Code and Telephone No.	
Appellant's Area Code and Telephone No.		Supervisor's Office (include Street Address, City, State, ZIP Code)		

Appellant's Mailing Address (Street or P.O. Box, City, State, ZIP Code)	County Name	County Code
Appellant's Residence Address (Street, City, State, ZIP Code)	County Name	County Code

1. Program (check applicable boxes)

Texas Works

☐ **A. SNAP** ☐ **B. SNAP- Employment Related Services** ☐ **C. TANF** ☐ **D. TANF- Employment Services Related**

For Items E. and F., enter appropriate code in box:

☐ **E. TANF Level Medicaid** ☐ **F. TW Medicaid (04, 07, 11, 20, 29, 30, 37, 40, 43, 44, 45, 46, 47, 48, 55, 71 or 72)** ☐ **W. Women's Health Program**

Long Term Care Services

☐ **G. Medicaid Eligibility** ☐ **H. Community Care** ☐ **I. Nursing Facility** ☐ **J. State Office Programs (that is, MH/IID)**

☐ **K. PASARR** ☐ **L. Other:** ____________________ ☐ **M. STAR+PLUS**

☐ **N. North Star** ☐ **P. Acute Care Medicaid** ☐ **Q. Acute Care Managed** ☐ **R. Acute Care Managed Plus** ☐ **S. CCP**

2. Agency Action Resulting in Hearing Request (check applicable boxes)

☐ **A. Application for Assistance Denied** ☐ **B. Assistance Discontinued** ☐ **C. Benefit Amount** ☐ **D. Not Benefit Amount Related**

3. Are benefits/services continued as a direct result of the appeal? .... ☐ **Yes** ☐ **No**

4. Has household specifically waived continued benefits/services? .... ☐ **Yes** ☐ **No**

5. Date the agency was notified of the appeal. ____________________

6. How was the agency notified of the appeal request? .... ☐ **Telephone Call** ☐ **Office Visit** ☐ **Written Request**

7. a. Date of Agency action being appealed: ____________________ b. Action effective date: ____________________

8. Summary of agency action and applicable handbook reference(s) or rules:

9. Is an interpreter required? .... ☐ **Yes** ☐ **No**

If yes, specify language: ____________________

10. Does the appellant require special accommodations to participate in the hearing?………… ☐ **Yes** ☐ **No**
If yes, give reason and describe accommodation required:

11. List the name, address and telephone number of additional witnesses/representatives (for example, home health agency nurse, family members, attorney/legal counsel, etc.

12. Does appellant have a designated representative on the application?………… ☐ **Yes** ☐ **No**
If yes, please complete the section below.

13. Does appellant have a representative not listed on the application?………… ☐ **Yes** ☐ **No**
If yes, please complete the section below.

Name of Representative or Legal Counsel	**Area Code and Telephone No.**
Address	

I hereby notify the hearings officer that this person is representing me in this appeal. This is my authorization for you to release to my representative copies of any factual data furnished to me before, during or after the appeal hearing.

If signed by "X," two witnesses are required.

Signature – Appellant **Date**

Signature – Witness **Signature – Witness**