Texas Health and Human
Services Commission

Form H4800-A
July 2010-E

Fair Hearing Request (Addendum)

To: Hearings 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 Sent ☐ **Electronic Mail** ☐ **Fax** ☐ **Mail**			Agency Representative's Office (include Street Address,City,State, ZIP Code)		
Appellant's Name			Agency Representative's Email Address		
Appellant's Case No.	EDG No. (TIERS cases only)	Appeal ID	Supervisor's Name	Supervisor's Area Code and Telephone No.	
Appellant's Area Code and Telephone No.			Supervisor's Address		
Appellant's Mailing Address (Street or P.O. Box, City, State, ZIP Code)			County Name	County Code	
Appellant's Residence Address (Street or P.O. Box, City, State, ZIP Code)			County Name	County Code	

1. Program (check only one box)

Texas Works

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

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

☐ **E. TANF Medicaid** _____ ☐ **F. TW Medicaid** _____ ☐ **W. Women's Health**

(04,07,11,20,29,30,37,40,43,44,45,46,47,48,55,71 or 72)

Long Term Care Services

☐ **G. Medicaid Eligibility** ☐ **H. Community Care** ☐ **I. Nursing Facility** ☐ **J. State Office Programs** ☐ **K. PASARR**

☐ **L. Other (that is, MH/IID Hearings):** _____ ☐ **M. STAR+PLUS**

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

2. Materials Attached

☐ **Agency Action Notice that prompted the appeal request** ☐ **Copies of Application Form and Related Worksheet(s)**

☐ **Other Related Materials (list)** **Agency policy related to appeal request:** _____

3. Additional Information

4. Schedule Hearing

Date: _____ **Time:** _____ ☐ **a.m** ☐ **p.m** ☐ **PT** ☐ **MT** ☐ **CT** ☐ **ET**

_____ _____
Signature–Case Manager/Agency Representative Date