TEXAS Health and Human Services

Form H4800
March 2023

Fair Hearing Request Summary

Section 1 – Agency Representative's Information				
Agency Representative Name:		Area Code and Phone No.:	Area Code and Fax No.:	Mail Code:
Address (Street, City, State and ZIP Code):				
Email Address:				
Appeal ID:	Region:	Unit No.:	Case No.:	Date sent to Hearing Office:

Section 2 – Supervisor's Information		
Supervisor Name:	Area Code and Phone No.:	Mail Code:
Address (Street, City, State and ZIP Code):		

Section 3 – Appellant's Information			
Appellant Name:			Date of Birth:
Area Code and Phone No.:	Area Code and Fax No.:		
Mailing Address (Street, City, State and ZIP Code):		County Name:	County Code:
Physical Address (Street, City, State and ZIP Code):		County Name:	County Code:
Email Address:			

Section 4 – Program Details			
Program Name:	EDG No. or SAVERR No.:	Type of Assistance:	Issue Code:
Issue Comment:			

1. Does the appeal meet the requirements for expedited processing? ◯ Yes ◯ No

2. Are benefits or services continued as a direct result of the appeal? ◯ Yes ◯ No

   a. Has household specifically waived continued benefits or services? ◯ Yes ◯ No

   b. Date waived: _____

   c. Was the appeal requested within 10 calendar days of agency action? ◯ Yes ◯ No

   d. Good cause? ◯ Yes ◯ No

3. Date agency was notified of appeal: _____

4. How was the agency notified of appeal?

5. Agency action:

a. Date of agency action being appealed: _____

b. Action effective date: _____

6. Was the action on appeal taken by an MCO, PAHP or PIHP? ◯ Yes ◯ No

7. Is an interpreter required? ◯ Yes ◯ No

a. If yes, specify language:

8. If an Acute Care service, is the appellant under 21 years old? ◯ Yes ◯ No

9. Was TMHP involved in the decision? ◯ Yes ◯ No

10. Name of provider agency, if appropriate:

11. Name of MCO, PAHP or PIHP, if appropriate:

12. Was an External Medical Review (EMR) requested? ◯ Yes ◯ No

a. Does the EMR meet the requirements for expedite processing? ◯ Yes ◯ No

b. Date Requested? _____

13. Does the appellant require special accommodations to participate in the hearing? ◯ Yes ◯ No

a. If yes, describe accommodation needed:

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

15. List the name, address, phone number, email address, mail code, and organization of any additional witnesses or representatives (for example, home health agency nurse, family members, attorney or legal counsel).

Name:	Area Code and Phone No.:
Address (Street, City, State and ZIP Code):	
Email Address:	
Organization Name:	Mail Code:

16. Does the appellant have a designated presentative on the application? ◯ Yes ◯ No If yes, please complete the section below.		
a. Name of Representative:	b. Area Code and Phone No.:	c. Area Code and Fax No.:
d. Address (Street, City, State and ZIP Code):		
e. Email Address:		
f. Is an interpreter needed? If yes, specify language:		
g. Is special accommodation needed? If yes, specify accommodation type:		

Section 5 – Signature(s)

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

Signature of Appellant (If signed by "X", two witnesses are required.) **Date**

Signature of Witness **Date**

Signature of Witness **Date**