REQUEST FOR MEDIATION AND/OR FAIR HEARING

PRIVACY STATEMENT - The information requested on this form, including name and address, is necessary for identification. Failure to provide the information requested may result in delays in services.

Consumer Name	SSN (last 4 digits) XXX-XX-	DOR Counselor Name
Telephone Number Check if TTY ☐	E-mail Address	
Residence Address	City	State Zip Code
Mailing Address, If Different	City	State Zip Code

Client Assistance Program (CAP)

If you need help filling out this form or want assistance in resolving a problem with the DOR, you may speak to a local CAP advocate. Call toll free at 1-800-776-5746 (voice), 1-800-719-5798 (TTY), or visit the CAP webpage www.disabilityrightsca.org/about/cap.html

I am dissatisfied with a decision or action by the DOR and request **one or both** of the following:

☐ **Mediation -** I request that an impartial mediator assist me and the DOR in resolving our different viewpoints regarding a DOR decision made or action taken within **one year of this request.**

(**Mediation will be held within 25 calendar days from receipt of your request, unless you agree to a later date.)**

☐ **Fair Hearing -** I request a hearing before an impartial hearing officer who will review a decision made or action taken by the DOR.

(Hearing requests must be made within 30 calendar days of your receipt of an Administrative Review Decision or within one year of the date of the decision or action with which you disagree.)

Explain the DOR decision made (and date), or action taken (and date) with which you disagree:

Why do you disagree and how do you want the problem solved?

Consumer Name	

Consumer' s Authorized Representative Name:	Client Assistance Program ☐ Yes ☐ No
Email Address	

Residence Address	City	State	Zip Code
Mailing Address, If Different	City	State	Zip Code

To participate in mediation and/or fair hearing, I will need the following accommodations (such as interpreters, assistive listening systems, or alternate formats):

By signing this form, I consent to the release of information on this form and the information necessary to carry out the mediation and/or fair hearing to the mediator(s), impartial hearing officer(s), mediation and/or hearing staff, and my representative.

Consumer Signature ✍	Date Signed

For both Mediation and/or Fair Hearing requests:

Mail the signed request to:
Mediation and Fair Hearing Office
c/o Department of Rehabilitation
Legal Affairs
P. O. Box 944222
Sacramento, CA 94244-2220

OR hand carry the signed request to:
Mediation and Fair Hearing Office
c/o Department of Rehabilitation
Legal Affairs
721 Capitol Mall, Sacramento, CA 95814-4702

OR fax the signed request to:
(916) 558-5861
Attention - Mediation and Fair Hearing Office

OR email the signed request
to:appealsinfo@dor.ca.gov

For information about mediation services and/or fair hearings call (916) 558-5860 (voice) or (916) 558-5862 (TTY) or visit the DOR webpage at http://www.dor.ca.gov/RAB/index.html