YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh (Food Stamps), or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh (Food Stamps) will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh (Food Stamps) or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh (Food Stamps) ☐ Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349.**

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ CalFresh (Food Stamps) ☐ Medi-Cal

☐ Other (list)_____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

REQUEST FOR COMPLAINT RESOLUTION

FOR AGENCY USE ONLY
LCSA DATE OF RECEIPT
LCSA CASE NUMBER

To request complaint resolution, you can either mail or deliver this form to the local child support agency you are complaining about, or call the local child support agency to file your complaint verbally.

COUNTY YOU ARE COMPLAINING ABOUT

COMPLAINANT' S NAME (Last) (First) (M.I.)		TELEPHONE NUMBER
COMPLAINANT'S MAILING ADDRESS	E-MAIL ADDRESS	FAX NUMBER
CITY	STATE	ZIP CODE

DESCRIBE YOUR COMPLAINT: (If you need more space, you may continue on another page and attach it to this form).

COMPLAINANT'S SIGNATURE	DATE

--THIS SECTION TO BE COMPLETED BY LCSA REPRESENTATIVE--

This request was taken (check one): ☐ in person ☐ by telephone ☐ by letter

LCSA REPRESENTATIVE'S NAME (Print)	LCSA REPRESENTATIVE'S SIGNATURE	DATE

COMPLAINT RESOLUTION - STATE HEARING INFORMATION

RIGHT TO COMPLAINT RESOLUTION:

- If you have a complaint against a local child support agency for any action or inaction regarding your child support case, you have the right to request complaint resolution from the local child support agency.
- You can make a complaint in writing by completing the Request for Complaint Resolution form, or you can call the local child support agency.
- ***IMPORTANT: Your request for complaint resolution must be made within 90 days from the date you knew, or should have known, about the subject of your complaint.***
- The local child support agency has 30 days from the date it receives your complaint to give you a written resolution of your complaint, unless the local child support agency needs more information or time to resolve your complaint. The local child support agency will contact you if it needs more information or time to resolve your complaint.

RIGHT TO A STATE HEARING:

- If the local child support agency ***does not*** respond to you within 30 days from receiving your complaint, you have the right to request a State Hearing before an Administrative Law Judge. ***IMPORTANT: Your request for a State Hearing must be made within 90 days after you complained to the local child support agency.***
- If the local child support agency ***does*** respond to you within 30 days of making your complaint, and you are not satisfied with the local child support agency's complaint resolution or response, you have the right to request a State Hearing before an Administrative Law Judge. ***IMPORTANT: Your request for State Hearing must be made within 90 days after you received the local child support agency's written response to your complaint.***
- You can request a State Hearing in writing by sending a Request for State Hearing form to the State Hearing Office, or you can call the State Hearing Office toll free at 1-866-289-4714.
- The State Hearing Office will let you know the date, time, and place of your State Hearing.
- The State Hearing Office will provide an interpreter or disability accommodation for you at the hearing if you need one.
- ***IMPORTANT: Not all complaints can be heard at a State Hearing.***

State Hearings will only be granted for the following issues:

- An application for child support has been denied or has not been acted upon within the required time frame.
- The child support services case has been acted upon in violation of federal or state law or regulation, or California Department of Child Support Services policy letter, or has not been acted on within the required timeframe, including services for the establishment, modification, and enforcement of child support orders and child support accountings.
- Child support collections have not been distributed, or have been distributed or disbursed incorrectly, or the amount of child support arrears, as calculated by the local child support agency is inaccurate.
- The local child support agency's decision to close a child support case.

IMPORTANT: The following issues cannot be heard at a State Hearing:

- Child support issues that must be addressed by motion, order to show cause, or appeal in a court.
- A review of any court order for child support or child support arrears.
- A court order or equivalent determination of paternity.
- A court order for spousal support.
- Child custody determinations.
- Child visitation determinations.
- Complaints of alleged discourteous treatment by a local child support agency employee, unless such conduct resulted in a hearable action or inaction.

OMBUDSPERSON SERVICES:

- Every local child support agency has an Ombudsperson available to help you through the complaint resolution and/or State Hearing process.
- The Ombudsperson can help you obtain information regarding your complaint to help you prepare for your State Hearing.
- ***IMPORTANT: The Ombudsperson cannot represent you at the State Hearing or give you legal advice.***

REQUEST FOR STATE HEARING

YOUR HEARING RIGHTS:
You have the right to request a state hearing if you are not satisfied with the local child support agency's resolution of your complaint, or if the local child support agency has not responded to you or resolved your complaint within 30 days of when you made your complaint. You have only 90 days to request a state hearing. The 90 days starts after you receive the local child support agency's written resolution to your complaint. If the local child support agency has not responded to your complaint in writing, the 90 days starts the day you made your complaint.

TO ASK FOR A STATE HEARING:

- Fill out this form.
- Keep a copy of this form for your records.
- Send this form to:

OR

Call toll free: 1-866-289-4714
Fax: 916-464-5069
Email to: StateHearings@dcss.ca.gov

Department of Child Support Services
Office of Legal Services
State Hearings
P.O. Box 419087
Rancho Cordova, CA 95741-9087

HEARING REQUEST INFORMATION:

COMPLAINANT NAME (Last) (First) (M.I.)			TELEPHONE NUMBER
MAILING ADDRESS			FAX NUMBER
CITY	COUNTY	STATE	ZIP CODE
E-MAIL ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER

Note: The Department of Child Support Services will not schedule a State Hearing unless you have first gone through the local child support agency complaint resolution process and it has been at least 30 days since you filed your complaint.

Please answer the following questions:

1. Have you gone through the complaint resolution process? ☐ Yes ☐ No
   If no, you must complete the complaint resolution process before you can request a state hearing.
2. Has it been more than 30 days since you requested complaint resolution? ☐ Yes ☐ No
3. Did you receive a resolution notice (Form LCR 006) from the local child support agency? ☐ Yes ☐ No
4. What county is your complaint against? _____
5. In what county do you want your hearing held? _____

I want a state hearing because: ***(If you need more room, you may continue on another page and attach it to this form.)***

CONTINUED ON REVERSE

REQUEST FOR STATE HEARING Page two

☐ I need the State to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing). My language or dialect is: _____

☐ I have a disability and need the State to provide me the following reasonable accommodation to participate at my hearing: _____

☐ I want the person named below to represent me at this hearing. I give my permission for this person to have access to my records or attend the hearing for me. (This person can be a friend or relative but cannot interpret for you).

NAME	TELEPHONE NUMBER	
STREET ADDRESS		
CITY Sacramento	STATE	ZIP CODE
COMPLAINANT'S SIGNATURE		DATE

RIGHT TO A STATE HEARING:

- If the local child support agency ***does not*** respond to you within 30 days from receiving your complaint, you have the right to request a State Hearing before an Administrative Law Judge. ***IMPORTANT: Your request for a state Hearing must be made within 90 days after you complained to the local child support agency.***
- If the local child support agency ***does*** respond to you within 30 days of making your complaint, and you are not satisfied with the local child support agency's complaint resolution or response, you have the right to request a State Hearing before an Administrative Law Judge. ***IMPORTANT: Your request for State Hearing must be made within 90 days after you received the local child support agency's written response to your complaint.***
- You can request a State Hearing in writing by sending a Request for State Hearing form (SH001) to the Department of Child Support Services, or you can call the Department of Child Support Services toll free at 1-866-289-4714.
- The Department of Child Support Services will let you know the date, time, and place of your State Hearing.
- The Department of Child Support Services will provide an interpreter or disability accommodation for you at the hearing if you need one.
- ***IMPORTANT: Not all complaints can be heard at a State Hearing.***

State Hearings will only be granted for the following issues:

- An application for child support has been denied or has not been acted upon within the required time.
- The child support services case has been acted upon in violation of federal or state law or regulation, or California Department of Child Support Services policy letter, including services for the establishment, modification, and enforcement of child support orders and child support accountings.
- Child support collections have not been distributed, or have been distributed or disbursed incorrectly, or the amount of child support arrears, as calculated by the local child support agency is inaccurate.
- The local child support agency's decision to close a child support case.

IMPORTANT: The following issues cannot be heard at a State Hearing:

- Child support issues that must be addressed by motion, order to show cause, or appeal in a court.
- A review of any court order for child support or child support arrears.
- A court order or equivalent determination of paternity.
- A court order for spousal support.
- Child custody determinations.
- Child visitation determinations.
- Complaints of alleged discourteous treatment by a local child support agency employee, unless such conduct resulted in a hearable action or inaction.

OMBUDSPERSON SERVICES:

- Every local child support agency has an Ombudsperson available to help you through the complaint resolution and/or State Hearing process.
- The Ombudsperson can help you obtain information regarding your complaint to help you prepare for your State Hearing.
- ***IMPORTANT: The Ombudsperson cannot represent you at the State Hearing or give you legal advice.***

How should I prepare for a state hearing?

The Ombudsperson can help you request a state hearing and prepare the documents you'll need. The following information will help you present your case:

1. Write a statement of the facts of your case.
2. Bring copies of any information, such as statements and notices, that support your case.
3. Prepare a list of witnesses and people who might be willing to speak on your behalf at the hearing.

The hearing will be held within 45 days after the State Hearing Office receives your request. You will be notified of the date, time and place of the hearing. If you are unable to attend, ask for a new hearing date or for the hearing to be held by telephone.

Free certified interpreter services are available. Reasonable accommodations are provided upon request. For assistance, call the State Hearing Office at (866) 289-4714

Complaint Resolution & State Hearing Timelines

You must file your complaint with the local child support agency within 90 days of the date you knew, or should have known, about the subject of your complaint.

You must request a state hearing within 90 days after the date you receive the LCSA's written response to your complaint.

If the LCSA does not respond to your complaint in writing, you must request a state hearing within 90 days from the date you filed your complaint with the LCSA.

The state hearing will be held within 45 days after the State Hearing Office receives your request.

Contact a local child support agency:

866-901-3212 toll-free
(within the U.S.)

TTY 866-399-4096

Arnold Schwarzenegger, *Governor*
State of California

Kimberly Belshé, *Secretary*
California Health and Human Services Agency

Jan C. Sturla, *Director*
Department of Child Support Services

TTY 1-866-223-9529 (toll-free)
www.childsup.ca.gov

PUB 253 (11/09)

Supporting California's Children

How to Resolve Problems with Your Child Support Case

Department of
Child Support Services

The Complaint Resolution Program

If you're not satisfied with the assistance you're receiving from the local child support agency (LCSA) you have the right to file a complaint through the Complaint Resolution Program.

The party who has/had custody or the parent who does not have custody may file a complaint if there is a case open with the LCSA.

Complaint issues that **can** be resolved through the Complaint Resolution Program include:

- Decision to open or close a case
- Failure to establish a court order for child support
- Collection and distribution of payments
- Calculation of past due payments
- Efforts to modify the child support amount
- Timeliness of service
- Enforcement efforts

Complaints that **cannot** be resolved through the program include:

- Court-ordered amount of child support or past due payments, custody, visitation, or spousal support, or determination of parental relationship
- Complaints about court services—contact the Family Law Facilitator at the courthouse, an advocate, or a lawyer for help
- Civil rights violations
- Services, if the complainant does not have a child support case open

How do I file a complaint?

State your complaint by phone or in person, or get a "Request for Complaint Resolution" form from your LCSA or the California Department of Child Support Services website, *www.childsup.ca.gov.* Submit the complaint form to the LCSA by mail or in person.

You must file your complaint with the LCSA within 90 days of the date you knew—or should have known—about the subject of your complaint.

Talk to the Ombudsperson!

If you need help with a problem, ask to speak with the LCSA's Ombudsperson—it is his or her job to:

- Help you get child support services
- Explain your rights and responsibilities
- Help you resolve problems with your case
- Explain the complaint process before, during, and after a complaint is filed
- Help you request and prepare for a state hearing if you are not satisfied with the results of the complaint resolution process

What will be done about my complaint?

Someone other than the caseworker involved with your complaint will investigate and try to resolve your complaint, and will tell the LCSA what must be done to remedy the problem. The complaint investigator will contact you soon after he or she receives your complaint.

The LCSA is required to provide a resolution in writing to every complaint within 30 days. If necessary, the LCSA can extend the complaint resolution period a maximum of 30 additional days. If the complaint resolution period is extended, the LCSA is required to mail you a notice stating the reason.

The LCSA will send you a written Notice of Complaint Resolution which will include information about your right to a state hearing in case you are not satisfied with the response to your complaint.

The State Hearing Program

If you are not satisfied with the LCSA's response to your complaint, you have the right to have your complaint issues heard at a state hearing.

The following disputes **cannot** be heard at a state hearing:

- Issues that must be addressed in court
- Court-ordered child support amounts
- Parental relationship/paternity
- Child custody or visitiation
- Contempt proceedings
- Civil rights violations
- Discourteous treatment by LCSA employee

How do I request a state hearing?

Talk to the Ombudsperson, or request a form from:

- Your local child support agency;
- The California Department of Child Support Services website, *www.childsup.ca.gov,*
- The State Hearing Office—call toll-free (866) 289-4714, fax (916) 464-5069, or email StateHearings@dcss.ca.gov;
- Write to: California Department of Child Support Services
  Office of Legal Services
  State Hearings, P. O. Box 419087
  Rancho Cordova, CA 95741-9087.

Employment Development Department
State of California

EDD Telephone Numbers:

English	1-800-300-5616
Spanish	1-800-326-8937
Cantonese	1-800-547-3506
Mandarin	1-866-303-0706
Vietnamese	1-800-547-2058
Self-Service	1-866-333-4606
TTY (non voice)	1-800 815-9387

EMPLOYMENT DEVELOPMENT DEPARTMENT APPEAL FORM

If you want to appeal a Department determination, please explain why you disagree and return this form to the Department using the office address listed on the enclosed notice. You have 20 days from the date of the notice to file an appeal. The 20-day period may be extended for good cause. Reasons for filing an appeal after 20 days must be explained and failure to do so may result in closure of your case.

Please note that claimants for Disaster Unemployment Assistance have 60 days to file an appeal. Employers who are appealing the Department's DE 3807 Notice of Determination or Assessment have 30 days to file an appeal.

I disagree with the Department's decision dated _____ because:

_____

_____

_____

_____

_____

_____

(Attach an additional sheet if more space is required)

CLAIMANTS: While your appeal is pending, you must continue to file a continued claim form for the period that you want to claim benefits. If you are found eligible, you can be paid only for periods for which you have filed continued claim forms and have met all other eligibility requirements. For more information on appeal hearings, visit www.cuiab.ca.gov/documents/hip_english.pdf.

The following information must be provided by the party filing the appeal (Appellant) or an authorized agent of the party filing the appeal. Signature of the appellant or agent is required.

Do you need a translator? ☐ Yes ☐ No If yes, please give language and dialect: _____

Appellant Name: _____ Appellant Telephone No.: (___) ___-____

Appellant Fax No.: (___) ___-____ Appellant Cell Phone No.: (___) ___-____

Appellant E-mail Address: _____

Do you give permission for the California Unemployment Insurance Appeals Board to send confidential information regarding your appeal to this e-mail address? ☐ Yes ☐ No

Do you give permission for the California Unemployment Insurance Appeals Board to send confidential information regarding your appeal to your cell phone number listed above by text message or voice mail so that information may be received sooner? ☐ Yes ☐ No

Appellant Mailing Address: _____ _____ ___ _____
Street No., Apt. No., or P.O. Box | City | State | ZIP Code

Claimant Name: _____

Claimant Social Security Number: ___-__-____

Employer Account Number: ___-____-_
(For employer appeal only)

Agent Name (If applicable): _____

Mailing Address: _____ _____ ___ _____
Street No., Apt. No., or P.O. Box | City | State | ZIP Code

Signature
Appellant or Agent: _____ Date: _____

Employment Development Department
State of California

Números de Teléfono del EDD:
español 1-800-326-8937
inglés 1-800-300-5616
Autoservicio 1-866-333-4606

FORMULARIO DE APELACIÓN DEL DEPARTAMENTO DEL DESARROLLO DEL EMPLEO (EDD)

Si Ud. desea apelar una decisión del Departamento, por favor explique la razón por la cual no está de acuerdo y regrese este formulario al Departamento, usando la dirección que aparece en la notificación adjunta. Usted tiene 20 días a partir de la fecha de esta notificación para presentar una apelación. El plazo de 20 días puede extenderse por razón justificada. Debe explicar las razones por presentar su apelación después del plazo de 20 días, de lo contrario, podría resultar en el cierre de su caso.

Por favor, tenga en cuenta que los solicitantes de Asistencia por Desempleo debido a Desastres (DUA) tienen 60 días para presentar una apelación. Los empleadores que están apelando la Notificación de Decisión o Evaluación (DE 3807) del Departamento, tienen 30 días para presentar una apelación.

Yo no estoy de acuerdo con la decisión del Departamento fechada el _____ porque:

(Adjunte una hoja adicional si necesita más espacio)

SOLICITANTES DE BENEFICIOS: Mientras su apelación esté pendiente, Ud. tiene que continuar presentando una solicitud de beneficios continuos por el período que Ud. desea solicitar beneficios. Si se determina que Ud. es elegible para beneficios, sólo se le puede pagar por los períodos para los cuales Ud. ha presentado solicitudes de beneficios continuos, y para los cuales haya reunido todos los otros requisitos de elegibilidad. Para más información sobre la audiencia de apelación, visite www.cuiab.ca.gov/documents/hip_español.pdf

La siguiente información tiene que ser proporcionada por la persona que está apelando (Apelante) o el agente autorizado de la persona que está apelando. La firma del apelante o del agente del apelante es requerida.

¿Necesita un(a) traductor(a)? ☐ Sí ☐ No Si marcó sí, por favor, especifique el idioma y dialecto: _____

Nombre del/de la Apelante: _____ No. de Teléfono del/de la Apelante: (___) ___-____

No. de Fax del/de la Apelante: (___) ___-____ No. de Teléfono Celular del/de la Apelante: (___) ___-____

Dirección de correo electrónico del/de la Apelante: _____

¿Le concede permiso a la Junta de Apelaciones del Seguro de Desempleo de California de enviar información confidencial con respecto a su apelación a esta dirección de correo electrónico? ☐ Sí ☐ No

¿Le concede permiso a la Junta de Apelaciones del Seguro de Desempleo de California de enviar información confidencial con respecto a su apelación a su número de teléfono celular que aparece arriba, por mensaje de texto o correo de voz, para que esta información la reciba más pronto? ☐ Sí ☐ No

Dirección Postal del/de la Apelante: _____ (No. de Calle., No. de Dept., o Apartado Postal) _____ (Ciudad) _____ (Estado) _____ (Código Postal)

Nombre del/de la Solicitante de Beneficios: _____

Número de Seguro Social del/de la Solicitante: ___-__-____

Número de Cuenta del Empleador: ___-____-_
(Para la apelación del Empleador solamente)

Nombre del Agente (Si es pertinente): _____

Dirección Postal: _____ (No. de Calle., No. de Dept., o Apartado Postal) _____ (Ciudad) _____ (Estado) _____ (Código Postal)

Firma del Apelante o Agente: _____ Fecha: _____

- English version on the other side -

CALIFORNIA UNEMPLOYMENT INSURANCE APPEALS BOARD

C·U·I·A·B

CUIAB - BOARD APPEAL

If you disagree with the unfavorable CUIAB Administrative Law Judge's (ALJ) decision you must file your Board Appeal within 20 calendar days, or 30 days for tax petitions, (including weekends and holidays) from the date listed on the front of the ALJ's decision. Claimants: If you wish to claim benefits while your appeal is pending you must continue to file claim forms. If you are found ineligible you may be required to repay benefits received. Please direct all claim questions to the Employment Development Department (EDD) at: http://www.edd.ca.gov

Check who is filing the Appeal: ☐ Employee ☐ Employer + Account No.: _____ ☐ EDD

ALJ Decision Case Number(s): _____ Date(s) of ALJ Decision(s): _____

Name: _____ Claimant Social Security No.: _____ _____ _____

Telephone No.: (____)_____ Alternate Telephone No.: (____)_____

Fax No.: (____)_____ E-mail Address: _____

Appellant Mailing Address: _____ _____ _____ _____
Street No., Apt. No., P.O. Box City State Zip Code

Do you give permission for the CUIAB to send confidential information regarding your appeal to this e-mail address (Information may be received sooner via e-mail)? ☐ Yes ☐ No ☐ Check box if mailing address has changed

Agent or Representative Name (If applicable): _____

Mailing Address: _____ _____ _____ _____
Street No., Apt. No., P.O. Box City State Zip Code

☐ Check box if you are not filing your appeal on time and explain the delay with specific details.

_____

_____

_____

☐ Check box if presenting new or additional evidence. Attach documents and explain why they were not presented at the hearing.

_____

_____

_____

I disagree with the Administrative Law Judge's decision because:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(If you need additional space please use the lines on the back of this page)

Signature Required: _____ **Date:** _____

CALIFORNIA UNEMPLOYMENT INSURANCE APPEALS BOARD

C·U·I·A·B

CUIAB - APELACION DE JUNTA

Si usted no está de acuerdo con la decisión en su contra del Juez Administrativo de CUIAB usted debe apelar a la Junta y entregar su apelación dentro de 20 días del calendario, o 30 días para petición de impuestos, (incluyendo fines de semana y días festivos) a partir de la fecha anotada en el frente de la decisión del Juez. Reclamante: Si usted desea reclamar beneficios mientras su apelación está pendiente, usted debe continuar mandando sus formularios. Si usted es notificado que no es elegible usted puede ser requerido a pagar el dinero que usted recibió de beneficios. Por favor dirija todas sus preguntas sobre los formularios a la oficina del Departamento del Desarrollo del Empleo (EDD) a: http://www.edd.ca.gov.

Marque quién está apelando: ☐ Empleado ☐ Empleador + No. de cuenta: _____ ☐ EDD

No(s). de Caso(s) de la Decisión del Juez: _____ Fecha(s) de la Decisión(es) del Juez: _____

Nombre: _____ No. de Seguro Social del Reclamante: _____ _____ _____

No. de Teléfono: (____)_____ No. de Teléfono Alterno: (____)_____

No. de Fax: (____)_____ Dirección de Correo Electrónico: _____

Dirección del Apelante: _____ _____ _____ _____
No. de Calle., No. de Apt., P.O. Box Ciudad Estado Código Postal

Da usted permiso para que CUIAB le mande información confidencial relacionada con su apelación a la dirección de correo electrónico (La información puede ser enviada más rápida por e-mail) ☐ Si ☐ No ☐ Marque la casilla si cambió su dirección de correo

Nombre del Agente o Representante (Si aplica): _____

Dirección: _____ _____ _____ _____
No. de Calle., No. de Apt., P.O. Box Ciudad Estado Código Postal

☐ Marque la casilla si su apelación fue presentada tarde y explique con detalles específicos la razón de la tardanza.

☐ Marque la casilla si usted está pidiendo presentar evidencia nueva o adicional. Adjunte los documentos y explique el porqué no fueron presentados en el momento de su audiencia.

No estoy de acuerdo con la decisión del Juez Administrativo porque:

(Si necesita espacio adicional por favor use el lado reverso de esta página)

Firma Requerida: _____ **Fecha:** _____

Information & Assistance Unit guide 1

How to file a workers' compensation claim form

Use a claim form to report a work injury or illness to your employer.

Attached is the employee claim for workers' compensation benefits. Please read and follow the instructions on the top of the form.

Complete only the "employee" section. Be sure to sign and date the claim form and keep a copy for your records.

Return the claim form to your employer right away in person or by mail. If you mail the claim form, use certified mail -- return receipt requested -- so you have a record of the date it was mailed and the date it was received. If you don't return the completed form to your employer you may risk your right to benefits.

You have the right to receive up to $10,000 in medical care under treatment guidelines while your employer decides whether to accept or deny your claim. Your employer must approve that treatment within one working day of receiving your claim form.

Your employer should fill out the "employer" section and forward the completed claim form to the insurance company. Your employer should give you a copy of the completed claim form. If they don't, request a copy and keep it for your records. Generally, the insurance company has 14 days to mail you a letter telling you the status of your claim. If you don't receive this letter, call the insurance company to find out the status of your claim.

- ✓ Workers' Compensation Claim Form (DWC 1)

If you need help, call an Information and Assistance (I&A) office, or attend a workshop for injured workers. The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dwc.ca.gov.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR forms handbook for further instructions.

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92806-2131
1065 N. PacifiCenter Drive, Suite 202
Information & Assistance Unit **(714) 414-7401**

BAKERSFIELD, 93301-1929
1800 30th Street, Suite 100
Information & Assistance Unit **(661) 395-2514**

EUREKA, 95501-0481
100 "H" Street, Suite 202
Information & Assistance Unit **(707) 441-5723**

FRESNO, 93721-2219
2550 Mariposa Mall, Suite 4078
Information & Assistance Unit **(559) 445-5355**

GOLETA, 93117-5551
6755 Hollister Avenue, Suite 100
Information & Assistance Unit **(805) 968-4158**

LONG BEACH, 90802-4304
300 Oceangate Street, Suite 200
Information & Assistance Unit **(562) 590-5240**

LOS ANGELES, 90013-1105
320 West 4th Street, 9th Floor
Information & Assistance Unit **(213) 576-7389**

MARINA DEL REY, CA 90292-6902
4720 Lincoln Boulevard, 2nd and 3rd floors
Information & Assistance Unit **(310) 482-3858**

OAKLAND, 94612-1499
1515 Clay Street, 6th Floor
Information & Assistance Unit **(510) 622-2861**

OXNARD, 93030-7912
1901 N. Rice Avenue, Suite 100
Information & Assistance Unit **(805) 485-3528**

POMONA, 91768-2653
732 Corporate Center Drive
Information & Assistance Unit **(909) 623-8568**

REDDING, 96001-2740
2115 Civic Center Drive, Suite 15
Information & Assistance Unit **(530) 225-2047**

RIVERSIDE, 92501-3337
3737 Main Street, Suite 300
Information & Assistance Unit **(951) 782-4347**

SACRAMENTO, 95834-2962
160 Promenade Circle Suite 300
Information & Assistance Unit **(916) 928-3158**

SALINAS, 93906-2204
1880 North Main Street, Suites 100 & 200
Information & Assistance **(831) 443-3058**

SAN BERNARDINO, 92401-1411
464 West Fourth Street, Suite 239
Information & Assistance Unit **(909) 383-4522**

SAN DIEGO, 92108-4424
7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2082**

SAN FRANCISCO, 94102-7002
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

SAN JOSE, 95113-1402
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

SAN LUIS OBISPO, 93401-8736
4740 Allene Way, Suite 100
Information & Assistance Unit **(805) 596-4159**

SANTA ANA, 92701-4070
605 W Santa Ana Boulevard, Bldg 28, Suite 451
Information & Assistance Unit **(714) 558-4597**

SANTA ROSA, 95404-4771
50 "D" Street, Suite 420
Information & Assistance Unit **(707) 576-2452**

STOCKTON, 95202-2314
31 East Channel Street, Suite 344
Information & Assistance Unit **(209) 948-7980**

VAN NUYS, 91401-3370
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit **(818) 901-5374**

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
   _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

Case No.

SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

First Name MI

Last Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

City State Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (If known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born _____ (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) _____ (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☐ specific injury _____ (Date of injury: MM/DD/YYYY)

suffered a :

☐ cumulative injury which began on _____ (Start Date: MM/DD/YYYY) and ended on _____ (End Date: MM/DD/YYYY)

The injury occurred at _____
Street Address/PO Box - Please leave blank spaces between numbers, names or words

City State Zip Code .

(State which parts of the body were injured)

Body Part 1: _____

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

3. Actual earnings at the time of injury:

Rate of Pay $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: _____ MM/DD/YYYY

First Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

Second Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

5. Compensation:

Compensation was paid: ☐ Yes ☐ No

Total paid: _____

Weekly rate(s): _____

Date of last payment: _____ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☐ Yes ☐ No

7. Medical treatment:

Medical treatment was received: ☐ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☐ No

Date of last treatment: _____
MM/DD/YYYY

Other treatment was provided/paid by: _____
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☐ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

_____
Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

_____
Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

_____ _____
Case Number 1 Case Number 3

_____ _____
Case Number 2 Case Number 4

9. This application is filed because of a disagreement regarding liability for:

☐ Temporary disability indemnity
☐ Reimbursement for medical expense
☐ Medical treatment
☐ Compensation at proper rate
☐ Permanent disability indemnity
☐ Rehabilitation
☐ Supplemental Job Displacement/Return to Work
☐ Other (Specify) _____

Is the Applicant Represented? ☐ Yes ☐ No **If "No", applicant is to sign and date below.**

If "Yes", applicant's representative is to complete the following and is to sign and date below.

☐ Law Firm/Attorney ☐ Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Applicant Attorney/Representative Signature

Applicant Signature

Dated at _____, California
City

Date _____
MM/DD/YYYY

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway,or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

Service of Documents

Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.

STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF LABOR STANDARDS ENFORCEMENT
STATE LABOR COMMISSIONER

FOR OFFICE USE ONLY – NO ESCRIBA EN ESTA SECCION		
Taken by	Wage Adjudication	
Date filed	Action	SIC Number

Initial Report or Claim/ Reporte Inicial O Reclamo

PLEASE PRINT ALL INFORMATION / POR FAVOR ESCRIBA CON LETRA DE MOLDE TODA LA INFORMACIÓN

If interpreter needed, what language?/Si necesita un interprete, que idioma? :_____

Your name / Su nombre	Interpreter needed Interprete requerido ☐ Yes ☐ No	Social Security Number No. de Seguro Social	Date of birth Fecha de nacimiento
Your address – Number and street, apartment or space no. Su domicilio – No. y calle, apartamento o no. de espacio	Home phone no. Teléfono - casa ( )	Work phone no. / current No. de teléfono de su trabajo actual ( )	
City, State, Zip Code / Ciudad, Zona Postal	California Driver's License No. / CA. I.D. Number No. de Licencia de Conducir o Identificación de California		

AGAINST / EN CONTRA

Name of business / Nombre del negocio Employer's vehicle license no./Numero de licencia del vehículo del empleador:_____	☐ Corporation ☐ Sole owner ☐ Partnership	☐ Sociedad anonima ☐ Propietario ☐ Sociedad
Address of business, City, State, Zip Code / Dirección del negocio, Ciudad, Zona Postal	☐ LLC-LLP ☐ Bankruptcy ☐ Business sold ☐ Business closed	☐ LLC-LLP ☐ Bancarrota ☐ Negocio vendido ☐ Negocio cerrado

Name of person in charge / Nombre de la persona a cargo	Telephone no. / No. de teléfono	Type of business / Tipo de negocio	No. of employees No. de empleados
Type of work performed / Ocupación, tipo de trabajo hecho	Date of hire Fecha de empleo	Public Works Project? ¿Proyecto de Obras Públicas? ☐ Yes ☐ No	Was your job union? ¿Pertenecía Ud. a un sindicato? ☐ Yes ☐ No
Location where work performed - Number. and Street , City , County, Zip Code / Lugar donde trabajó - No. de Calle, Ciudad, Condado, Zona Postal			

WAGES - CONDITIONS OF EMPLOYMENT / SUELDO - CONDICIONES DE EMPLEO

Rate of pay - per hour, day, week or month or piece rate (specify) Tasa de pago –por hora, día, semana, mes o por pieza (especifique) $	Total hours worked / Total de horas trabajadas By day Por día By week Por semana	Paid Overtime? ¿Le pagaban el sobretiempo? ☐ Yes ☐ No
Are you still working for this employer? ¿Aún sigue trabajando para este patrón? ☐ Yes ☐ No	☐ Discharged Despedido ☐ Quit Renuncié On what date? ¿En que fecha?	Were you paid at time of discharge? ¿Le pagarón cuando lo despidierón? ☐ Yes ☐ No
If quit, did you give 72 hours notice? ¿Si renunció, dió Ud. 72 horas de aviso? ☐ Yes ☐ No	Have you asked for your wages? ¿Ha solicitado su sueldo? ☐ Yes ☐ No	If yes, on what date? Si es que si, ¿en que fecha?
		☐ In person / En persona ☐ By mail / Por correo
How were you paid? ¿Cómo le pagaban? ☐ By check / con cheque ☐ In cash / en efectivo	Given a deduction slip? ☐ Yes ☐ No ¿Le dierón un talón de deducciones?	Did you keep a record of hours worked? ☐ Yes ☐ No ¿Tiene récord de las horas trabajadas?

GROSS WAGES CLAIMED / GANANCIAS EN BRUTO RECLAMADAS

From (date) / De (Fecha) mo. / date / yr.	To (date) / A (Fecha) mo. / date / yr.	Number of hours, days, weeks or months (Specify: vacation, commission, expenses, overtime) No. de horas, días, semanas o meses reclamados (Especifique: vacaciones, comisión, gastos, sobretiempo)	
At the rate of - per hour, day, week or month (specify) Al pago de - por hora, diá, semana o mes (especifique) $		Gross amount claimed Cantidad en bruto reclamada	$
Brief explanation of issues (use additional sheet if necessary) Breve explicación de los hechos (use papel adicional si es necesario)		Less amount paid: Menos la candidad recibida	$
		Amount claimed: **Cantidad o saldo reclamado:**	$

I hereby certify that this is a true statement to the best of my knowledge/Por el presente, que esta es una declaración verídica conforme a mi conocimiento.

Signed: _____ Date: _____

DO NOT WRITE ON THIS SIDE - *For Office Use Only*

Claimant :	Against :	Action Number	
Address :	Address :	Docket Date	Date Closed
		DATE (S) CLAIM RECEIVED	
Address change as of :	Address change as of:		

RECORD OF RECEIPTS				**RECORD OF PAYMENTS TO CLAIMANT**			
Date Received	Check, Cash, Etc.	Receipt Number	Amount	Division Check Number	Date Paid	Balance Due	Signature / Remarks

CONFERENCE: DATES			**PEND: DATES**				

Direct any correspondence to
LABOR COMMISSIONER, STATE OF CALIFORNIA

RETALIATION COMPLAINT

FOR OFFICE USE ONLY

TAKEN BY	DATE	OFFICE
VIOLATION OF SECTION		NAME OF CODE
ASSIGNED INVESTIGATOR		CASE NUMBER

PLEASE PRINT ALL INFORMATION

NAME	HOME TELEPHONE NO.	CURRENT WORK PHONE NO.

YOUR ADDRESS-NUMBER AND STREET, APARTMENT OR SPACE NUMBER, CITY, ZIP CODE

SEX	SOCIAL SECURITY	CALIFORNIA DRIVER LICENSE NO.	DATE OF BIRTH

NAME OF BUSINESS	EMPLOYER'S NAME	☐ CORPORATION ☐ PARTNERSHIP ☐ SOLE OWNER

ADDRESS OF BUSINESS-NUMBER AND STREET, CITY, ZIP CODE	TELEPHONE NUMBER

ADDRESS WHERE YOU WORKED IF DIFFERENT THAN ABOVE	DATE OF HIRE?

YOUR DEPARTMENT AND JOB TITLE	RATE OF PAY	NUMBER OF HOURS WORKED? PER DAY PER WEEK

NAME OF SUPERVISOR	TYPE OF BUSINESS	ESTIMATED NO. EMPLOYEES

WAS YOUR JOB UNION?	IF YES, NAME AND ADDRESS OF UNION?	TELEPHONE

WERE YOU DISCHARGED? ☐ YES ☐ NO	IF YES-DATE	BY WHOM? NAME AND TITLE	ARE YOU STILL WORKING FOR THIS EMPLOYER? ☐ YES ☐ NO

DID YOU NOTIFY YOUR EMPLOYER OF INTENTION TO FILE A CLAIM WITH THE LABOR COMMISSIONER? ☐ YES ☐ NO	IF YES-DATE	NAME AND TITLE OF PERSON NOTIFIED?

DID YOU FILE A SAFETY COMPLAINT? ☐ YES ☐ NO	IF YES-DATE	WITH WHOM-NAME AND ADDRESS?

DID YOU NOTIFY OSHA? ☐ YES ☐ NO	IF YES-DATE	WHICH OFFICE?

NAME AND TITLE OF PERSON(S) YOU BELIEVE RETALIATED AGAINST YOU?

WHAT REMEDY ARE YOU SEEKING THROUGH THIS DIVISION?

HAVE YOU FILED WITH ANY OTHER GROUP OR AGENCY? ☐ YES ☐ NO IF YES, WHICH OFFICE?

NAME ADDRESS TELEPHONE

ARE YOU BEING REPRESENTED BY AN ATTORNEY? ☐ YES ☐ NO

NAME ADDRESS TELEPHONE

INTERPRETER NEEDED? ☐ YES ☐ NO	IF INTERPRETER NEEDED, WHAT LANGUAGE?

LIST NAME, JOB TITLES AND TELEPHONE NUMBER (IF POSSIBLE) OF WITNESSES, CO-WORKERS OR THOSE YOU FEEL COULD PROVIDE EVIDENCE IN YOUR SUPPORT TO THE ACTS YOU ARE COMPLAINING ABOUT. USE ADDITIONAL SHEETS

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF LABOR STANDARDS ENFORCEMENT

Give a written statement answering each of the questions in the space provided below. After answering these questions, if you wish, you may also attach additional sheets to provide a more detailed description of the circumstances of the retaliatory act.

1. Protected activity (What did you do that caused your employer to retaliate against you?)

Date of protected activity: _____

2. Employer knowledge (How did your employer know you engaged in a protected activity?)

Date of employer knowledge: _____

3. Adverse action (What did your employer do to you because you engaged in a protected activity?)

Date of adverse action: _____

I certify under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct

EXECUTED ON, _____, AT _____CALIFORNIA

SIGNATURE

_____

IF ADDITIONAL PAGES ARE USED, YOU MUST INITIAL, DATE AND NUMBER EACH PAGE.

SOCIAL SECURITY ADMINISTRATION | TOE 710 | Form Approved OMB No. 0960-0622

REQUEST FOR RECONSIDERATION

(Do not write in this space)

NAME OF CLAIMANT		NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant.)*
CLAIMANT SSN – –	CLAIMANT CLAIM NUMBER (if different from SSN) – –	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER – –
SPOUSE'S NAME *(Complete ONLY in SSI cases)*		SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)* – –

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital /medical, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See the three ways to appeal in the How To Appeal Your Supplemental Security Income (SSI) Or Special Veterans Benefit (SVB) Decision instructions.)

"I want to appeal your decision about my claim for Supplemental Security Income (SSI) or Special Veterans Benefits (SVB). I've read about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY		
MAILING ADDRESS			MAILING ADDRESS		
CITY	STATE	ZIP CODE –	CITY	STATE	ZIP CODE –
TELEPHONE NUMBER *(Include area code)* ( ) –	DATE		TELEPHONE NUMBER *(Include area code)* ( ) –	DATE	

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

See list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO

2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO

3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
(If "NO", attach claimant's explanation for delay and attach any pertinent letter, material, or information in Social Security office.)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.300)

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS

ROUTING INSTRUCTIONS (CHECK ONE) →

☐ DISABILITY DETERMINATION SERVICES *(ROUTE WITH DISABILITY FOLDER)*
☐ ODO, BALTIMORE
☐ PROGRAM SERVICE CENTER
☐ OIO, BALTIMORE
☐ OEO, BALTIMORE
☐ DISTRICT OFFICE RECONSIDERATION
☐ CENTRAL PROCESSING SITE (SVB)

NOTE: Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records.

ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS
(See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title II

1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

Title XVI

1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)

1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II--items 3, 4, 10, 11 & 16.

Title XVIII

1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.

SOCIAL SECURITY ADMINISTRATION | TOE 710 | Form Approved OMB No. 0960-0622

REQUEST FOR RECONSIDERATION

(Do not write in this space)

NAME OF CLAIMANT		NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant.)*
CLAIMANT SSN – –	CLAIMANT CLAIM NUMBER (if different from SSN) – –	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER – –
SPOUSE'S NAME *(Complete ONLY in SSI cases)*		SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)* – –

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital/medical, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See the three ways to appeal in the How To Appeal Your Supplemental Security Income (SSI) Or Special Veterans Benefit (SVB) Decision instructions.)

"I want to appeal your decision about my claim for Supplemental Security Income (SSI) or Special Veterans Benefits (SVB). I've read about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY		
MAILING ADDRESS			MAILING ADDRESS		
CITY	STATE	ZIP CODE –	CITY	STATE	ZIP CODE –
TELEPHONE NUMBER *(Include area code)* ( ) –		DATE	TELEPHONE NUMBER *(Include area code)* ( ) –		DATE

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

See list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO

2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO

3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
(If "NO", attach claimant's explanation for delay and attach any pertinent letter, material, or information in Social Security office.)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.300)

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS

ROUTING INSTRUCTIONS (CHECK ONE) →

☐ DISABILITY DETERMINATION SERVICES *(ROUTE WITH DISABILITY FOLDER)*
☐ ODO, BALTIMORE
☐ PROGRAM SERVICE CENTER
☐ OIO, BALTIMORE
☐ OEO, BALTIMORE
☐ DISTRICT OFFICE RECONSIDERATION
☐ CENTRAL PROCESSING SITE (SVB)

NOTE: Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records.

HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

There are three different ways to appeal. You can pick the appeal that fits your case. You can have a lawyer, friend, or someone else help you with your appeal.

Here are the three ways to appeal:

1. CASE REVIEW:

You can give us more facts to add to your file. Then we'll decide your case again. You don't meet with the person who decides your case.

You can pick this kind of appeal in all cases.

2. INFORMAL CONFERENCE:

You'll meet with the person who will decide your case. You can tell that person why you think you're right. You can give us more facts to help prove you're right. You can bring other people to help explain your case.

You can pick this kind of appeal in all SSI cases *except* two. You can't have it if we turned down your SSI application for medical reasons or because you're not blind. Also you can't have it if we're giving you SSI but you disagree with the date we said you became blind or disabled. In SVB cases, you can pick this kind of appeal only if we're stopping or lowering your SVB payment.

3. FORMAL CONFERENCE:

This is a meeting like an informal conference. Plus, we can make people come to help prove you're right. We can do this even if they don't want to help you. You can question these people at your meeting.

You can pick this kind of appeal only if we're stopping or lowering your SSI or SVB payment. You can't get it in any other case.

Now you know the three kinds of appeals. You can pick the one that fits your case. Then fill out this form. We'll help you fill it out.

There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789-U4) FOR YOUR APPEAL.

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 -416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

Privacy Act Statement
Collection and Use of Personal Information

Section 205(a), of the Social Security Act as amended, [42 U.S.C. 405(a)] and Title 20 C.F.R. 404.907 - 404.922 and 416.1407 – 416.1422 authorize us to collect this information. We will use the information you provide to help us determine your entitlement to benefits. The information you provide on this form is voluntary. However, we cannot reconsider the decision on your claim unless you furnish this information.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information for Social Security records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. Information from these matching agencies can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notice entitled Claims Folder System 60-0089. The notice, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions. *Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0037

Request For Waiver Of Overpayment Recovery Or Change In Repayment Rate

FOR SSA USE ONLY	
ROAR Input	☐ Yes ☐ No
Input Date	
Waiver	☐ Approval ☐ Denial
SSI	☐ Yes ☐ No
AMT OF OP $	
PERIOD (DATES) OF OP	

We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we can't waive collection, we may use this form to decide how you should repay the money.

Please answer the questions on this form as completely as you can. We will help you fill out the form if you want. If you are filling out this form for someone else, answer the questions as they apply to that person.

1. A. Name of person on whose record the overpayment occurred: _____

B. Social Security Number _____

C. Name of overpaid person(s) making this request and his or her Social Security Number(s):

_____ _____

_____ _____

_____ _____

_____ _____

2. Check any of the following that apply. (Also, fill in the dollar amount in B, C, or D.)

A. ☐ The overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair for some other reasons.

B. ☐ I cannot afford to use all of my monthly benefit to pay back the overpayment. However I can afford to have $ _____ withheld each month.

C. ☐ I am no longer receiving Supplement Security Income (SSI) payments. I want to pay back $ _____ each month instead of paying all of the money at once.

D. ☐ I am receiving SSI payments. I want to pay back $ _____ each month instead of paying 10% of my total income.

SECTION I-INFORMATION ABOUT RECEIVING THE OVERPAYMENT

3. A. Did you, as representative payee, receive the overpaid benefits to use for the beneficiary?

☐ Yes ☐ No (Skip to Question 4)

B. Name and address of the beneficiary

C. How were the overpaid benefits used?

4. If we are asking you to repay someone else's overpayment:

A. Was the overpaid person living with you when he/she was overpaid? ☐ Yes ☐ No

B. Did you receive any of the overpaid money? ☐ Yes ☐ No

C. Explain what you know about the overpayment AND why it was not your fault.

5. Why did you think you were due the overpaid money and why do you think you were not at fault in causing the overpayment or accepting the money?

6. A. Did you tell us about the change or event that made you overpaid? ☐ Yes ☐ No
If no, why didn't you tell us?

B. If yes, how, when and where did you tell us? If you told us by phone or in person, who did you talk with and what was said?

C. If you did not hear from us after your report, and/or your benefits did not change, did you contact us again? ☐ Yes ☐ No

7. A. Have we ever overpaid you before? ☐ Yes ☐ No

If yes, on what Social Security number?

B. Why were you overpaid before? If the reason is similar to why you are overpaid now, explain what you did to try to prevent the present overpayment.

FOR SSA USE ONLY

NAME:

SSN:

SECTION II-YOUR FINANCIAL STATEMENT

You need to complete this section if you are asking us either to waive the collection of the overpayment or to change the rate at which we asked you to repay it. Please answer all questions as fully and as carefully as possible. We may ask to see some documents to support your statements, so you should have them with you when you visit our office.

EXAMPLES ARE:

- Current Rent or Mortgage Books
- Savings Passbooks
- Pay Stubs
- Your most recent Tax Return
- 2 or 3 recent utility, medical, charge card, and insurance bills
- Cancelled checks
- Similar documents for your spouse or dependent family members

Please write only whole dollar amounts-round any cents to the nearest dollar. If you need more space for answers, use the "Remarks" section at the bottom of page 7.

8. A. Do you now have any of the overpaid checks or money in your possession (or in a savings or other type of account)?

☐ Yes Amount: $_____ Return this amount to SSA

☐ No

B. Did you have any of the overpaid checks or money in your possession (or in a savings or other type of account) at the time you received the overpayment notice?

☐ Yes Amount: $_____ Answer Question 9.

☐ No

9. Explain why you believe you should not have to return this amount.

_____

_____

ANSWER 10 AND 11 ONLY IF THE OVERPAYMENT IS SUPPLEMENTAL SECURITY INCOME (SSI) PAYMENTS. IF NOT, SKIP TO 12.

10. A. Did you lend or give away any property or cash after notification of the overpayment?

☐ Yes (Answer Part B)

☐ No (Go to question 11.)

B. Who received it, relationship (if any), description and value:

_____

11. A. Did you receive or sell any property or receive any cash (other than earnings) after notification of this overpayment?

☐ Yes (Answer Part B)

☐ No (Go to question 12.)

B. Describe property and sale price or amount of cash received:

_____

12. A. Are you now receiving cash public assistance such as Supplemental Security Income (SSI) payments?

☐ Yes (Answer B and C and See note below)

☐ No

B. Name or kind of public assistance

C. Claim Number

_____ _____

IMPORTANT: If you answered "YES" to question 12, DO NOT answer any more questions on this form. Go to page 8, sign and date the form, and give your address and phone number(s). Bring or mail any papers that show you receive public assistance to your local Social Security office as soon as possible.

Members Of Household

13. List any person (child, parent, friend, etc.) who depends on you for support AND who lives with you.

NAME	AGE	RELATIONSHIP (If none, explain why the person is dependent on you)

Assets-Things You Have And Own

14. A. How much money do you and any person(s) listed in question 13 above have as cash on hand, in a checking account, or otherwise readily available? **$**

B. Does your name, or that of any other member of your household appear, either alone or with any other person, on any of the following?

TYPE OF ASSET	OWNER	BALANCE OR VALUE	PER MONTH (SHOW THE INCOME (interest, dividends) EARNED EACH MONTH. (If none, explain in spaces below. If paid quarterly, divide by 3).)	
SAVINGS (Bank, Savings and Loan, Credit Union)		$	$	
		$	$	
CERTIFICATES OF DEPOSIT (CD)		$	$	
INDIVIDUAL RETIREMENT ACCOUNT (IRA)		$	$	
MONEY OR MUTUAL FUNDS		$	$	
BONDS, STOCKS		$	$	
TRUST FUND		$	$	
CHECKING ACCOUNT		$	$	
OTHER (EXPLAIN)		$	$	
TOTALS —		$	$	Enter the "Per Month" total on line (k) of question 18.

15. A. If you or a member of your household own a car, (other than the family vehicle), van, truck, camper, motorcycle, or any other vehicle or a boat, list below.

OWNER	YEAR/MAKE/MODEL	PRESENT VALUE	LOAN BALANCE (if any)	MAIN PURPOSE FOR USE
		$	$	
		$	$	
		$	$	

B. If you or a member of your household own any real estate (buildings or land), OTHER than where you live, or own or have an interest in, any business, property, or valuables, describe below.

OWNER	DESCRIPTION	MARKET VALUE	LOAN BALANCE (if any)	USAGE-INCOME (rent etc.)
		$	$	
		$	$	
		$	$	
		$	$	

Monthly Household Income

If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every 2 weeks, multiply by 2.166 (2 1/6). If self-employed, enter 1/12 of net earnings. Enter monthly TAKE HOME amounts on line A of question 18 also.

16. A. Are you employed? ☐ YES (Provide information below) ☐ NO (Skip to B)

Employer name, address, and phone: (Write "self" if self-employed) | Monthly pay before deduction (Gross) $

Monthly TAKE-HOME pay (NET)	$

B. Is your spouse employed? ☐ YES (Provide information below) ☐ NO (Skip to C)

Employer(s) name, address, and phone: (Write "self" if self-employed) | Monthly pay before deduction (Gross) $

Monthly TAKE-HOME pay (NET)	$

C. Is any other person listed in Question 13 employed? ☐ YES Name(s) ☐ NO (Go to Question 17)

Employer(s) name, address, and phone: (Write "self" if self-employed) | Monthly pay before deduction (Gross) $

Monthly TAKE-HOME pay (NET)	$

17. A. Do you, your spouse or any dependent member of your household receive support or contributions from any person or organization? ☐ YES (Answer B) ☐ NO (Go to question 18)

B. How much money is received each month? (Show this amount on line (J) of question 18 $ | SOURCE

BE SURE TO SHOW **MONTHLY** AMOUNTS BELOW - If received weekly or every 2 weeks, read the instruction at the top of this page.

18.

INCOME FROM #16 AND #17 ABOVE AND OTHER INCOME TO YOUR HOUSEHOLD	YOURS	V	SPOUSE'S	V	OTHER HOUSEHOLD MEMBERS	V
A. TAKE HOME Pay (Net) (From #16 A, B, C, above)	$	☐	$	☐	$	☐
B. Social Security Benefits		☐		☐		☐
C. Supplemental Security Income (SSI)		☐		☐		☐
D. Pension(s) (VA, Military, Civil Service, Railroad, etc.) TYPE		☐		☐		☐
TYPE		☐		☐		☐
E. Public Assistance (Other than SSI) TYPE		☐		☐		☐
F. Food Stamps (Show full face value of stamps received)		☐		☐		☐
G. Income from real estate (rent, etc.) (From question 15B)		☐		☐		☐
H. Room and/or Board Payments (Explain in remarks below)		☐		☐		☐
I. Child Support/Alimony		☐		☐		☐
J. Other Support (From #17 (B) above)		☐		☐		☐
K. Income From Assets (From question 14)		☐		☐		☐
L. Other (From any source, explain below)		☐		☐		☐
REMARKS TOTALS	$		$		$	

GRAND TOTAL $
(Add 3 total blocks above)

Monthly Household Expenses

If the expense is paid weekly or every 2 weeks, read the instruction at the top of Page 5. Do NOT list an expense that is withheld from income (Such as Medical Insurance). Only take home pay is used to figure income.

Show "CC" as the expense amount if the expense (such as clothing) is part of CREDIT CARD EXPENSE SHOWN ON LINE (F).

19.		$ PER MONTH	SSA USE ONLY
	A. Rent or Mortgage (If mortgage payment includes property or other local taxes, insurance, etc. DO NOT list again below.)		
	B. Food (Groceries (include the value of food stamps) and food at restaurants, work, etc.)		
	C. Utilities (Gas, electric, telephone)		
	D. Other Heating/Cooking Fuel (Oil, propane, coal, wood, etc.)		
	E. Clothing		
	F. Credit Card Payments (show minimum monthly payment allowed)		
	G. Property Tax (State and local)		
	H. Other taxes or fees related to your home (trash collection, water-sewer fees)		
	I. Insurance (Life, health, fire, homeowner, renter, car, and any other casualty or liability policies)		
	J. Medical-Dental (After amount, if any, paid by insurance)		
	K. Car operation and maintenance (Show any car loan payment in (N) below)		
	L. Other transportation		
	M. Church-charity cash donations		
	N. Loan, credit, lay-away payments (If payment amount is optional, show minimum)		
	O. Support to someone NOT in household (Show name, age, relationship (if any) and address)		
	P. Any expense not shown above (Specify)		
	EXPENSE REMARKS (Also explain any unusual or very large expenses, such as medical, college, etc.)	TOTAL	$

Income And Expenses Comparison

20. A. Monthly income (Write the amount here from the "Grand Total" of #18.) $

B. Monthly Expenses (Write the amount here from the "Total" of #19.) $

C. Adjusted Household Expenses +$25

D. Adjusted Monthly Expenses (Add (B) and (C)) $ 25

21. If your expenses (D) are more than your income (A), explain how you are paying your bills.

FOR SSA USE ONLY	
☐ INC. **EXCEEDS** ADJ EXPENSE	$ +
☐ INC **LESS THAN** ADJ EXPENSE	$ -

Financial Expectation And Funds Availability

22. A. Do you, your spouse or any dependent member of your household expect your or their financial situation to change (for the better or worse) in the next 6 months? (For example: a tax refund, pay raise or full repayment of a current bill for the better-major house repairs for the worse).

☐ YES (Explain on line below)
☐ NO

B. If there is an amount of cash on hand or in checking accounts shown in item 14A, is it being held for a special purpose?

☐ NO (Amount on hand)
☐ NO (Money available for any use)
☐ YES (Explain on line below)

C. Is there any reason you CANNOT convert to cash the "Balance or Value" of any financial asset shown in item 14B.

☐ YES (Explain on line below)
☐ NO

D. Is there any reason you CANNOT SELL or otherwise convert to cash any of the assets shown in items 15A and B?

☐ YES (Explain on line below)
☐ NO

Remarks Space –

If you are continuing an answer to a question, please write the number (and letter, if any) of the question first.

(MORE SPACE ON NEXT PAGE)

REMARKS SPACE (Continued)

PENALTY CLAUSE, CERTIFICATION AND PRIVACY ACT STATEMENT

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF OVERPAID PERSON OR REPRESENTATIVE PAYEE

SIGNATURE (First name, middle initial, last name) (Write in ink)	DATE (Month, Day, Year)
	HOME TELEPHONE NUMBER (Include area code)
SIGN HERE	WORK TELEPHONE NUMBER IF WE MAY CALL YOU AT WORK (Include area code)

MAILING ADDRESS (Number and street, Apt. No., P.O. Box, or Rural Route)

CITY AND STATE	ZIP CODE	ENTER NAME OF COUNTY (IF ANY) IN WHICH YOU NOW LIVE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X),two witnesses to the signing who know the individual must sign below, giving their full addresses.

SIGNATURE OF WITNESS	SIGNATURE OF WITNESS
ADDRESS (Number and street, City, State, and ZIP Code)	ADDRESS (Number and street, City, State, and ZIP Code)

Privacy Act Statement

Collection and Use of Personal Information

Sections 204, 1631(b), and 1870 of the Social Security Act, as amended, and the Federal Coal Mine Health and Safety Act of 1969 authorize us to collect this information. The information you provide will be used to make a determination on waiving overpayment recovery or changing your repayment rate.

The information you furnish on this form is voluntary. However, failure to provide the requested information may prevent us from approving your request.

We rarely use the information you supply for any purpose other than for determining waiver or a change in the repayment rate of an overpayment recovery. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs; and To the Department of Justice when representing the Social Security Administration in litigation.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995 . You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 hours to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213 (TTY 1-800-325-0778).** *Send only comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.*

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. CLAIMANT NAME	CLAIMANT SSN - -	2. WAGE EARNER NAME, IF DIFFERENT
3 CLAIMANT CLAIM NUMBER, IF DIFFERENT - -	4. SPOUSE'S NAME, IF NOT WAGE EARNER	SPOUSE'S CLAIM NUMBER OR SSN - -

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. I have additional evidence to submit. ☐ Yes ☐ No

Name and address of source of additional evidence:

(Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)

7. Do not complete if the appeal is a Medicare issue.
Check one of the blocks:
☐ I wish to appear at a hearing.
☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.
Regardless of the issue you are appealing, you should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc., in No. 9.
I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

8. (CLAIMANT'S SIGNATURE) (DATE)	9. (REPRESENTATIVE'S SIGNATURE/NAME) (DATE)
ADDRESS	(ADDRESS) ☐ ATTORNEY; ☐ NON-ATTORNEY;
CITY STATE ZIP CODE -	CITY STATE ZIP CODE -
TELEPHONE NUMBER ( ) -	TELEPHONE NUMBER ( ) -
FAX NUMBER ( ) -	FAX NUMBER ( ) -

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION-ACKNOWLEDGMENT OF REQUEST FOR HEARING

10. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)
_____ (Title) _____ (Address) _____ (Servicing FO Code) _____ (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO
If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): _____

14. Check one:
☐ Initial Entitlement Case
☐ Disability Cessation Case
☐ Other Postentitlement Case

16. HO COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII;
☐ Title II CF held in FO ☐ Electronic Folder
☐ CF requested ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII
(Copy of email or phone report attached)

17. CF COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title XVIII
☐ Other Attached: _____

15. Check all claim types that apply:

☐ RSI only	(RSI)
☐ Title II Disability-worker or child only	(DIWC)
☐ Title II Disability-Widow(er) only	(DIWW)
☐ SSI Aged only	(SSIA)
☐ SSI Blind only	(SSIB)
☐ SSI Disability only	(SSID)
☐ SSI Aged/Title II	(SSAC)
☐ SSI Blind/Title II	(SSBC)
☐ SSI Disability/Title II	(SSDC)
☐ Title XVIII	(HI/SMI)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: _____	

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a) (42 U.S.C. 405 (a)), 702 (42 U.S.C. 902), 1631(e)(1)(A) and (B) (42 U.S.C. 1383(e)(1)(A) and (B)), 1839(i) (42 U.S.C. 1395r), and 1869(b)(1) and (c) (42 U.S.C. 1395ff) of the Social Security Act authorizes us to collect this information. We will use the information you provide to continue processing your claim. The information you provide on this form is voluntary. However, failure to provide all or part of the requested information could prevent us from making an accurate and timely decision on your claim.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to the Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigate activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded and administered benefit programs for repayment of payments or delinquent debts under these programs. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is available in our System of Records Notice entitled, Claims Folder System, 60-0089. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

SOCIAL SECURITY ADMINISTRATION/OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0277

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)

(Either mail the signed original form to the Appeals Council at the address shown below, or take or mail the signed original to your local Social Security office.)

See Privacy Act Notice

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT
3.SOCIAL SECURITY CLAIM NUMBER - -	4. SPOUSE'S NAME AND SOCIAL SECURITY NUMBER *(Complete ONLY in Supplemental Security Income Case)*

5. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

ADDITIONAL EVIDENCE

If you have additional evidence submit it with this request for review. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. If you request an extension of time, you should explain the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.

IMPORTANT: Write your Social Security Claim Number on any letter or material you send us.

SIGNATURE BLOCKS: You should complete No. 6 and your representative (if any) should complete No. 7. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 7.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

6. CLAIMANT'S SIGNATURE DATE	7. REPRESENTATIVE'S SIGNATURE ☐ ATTORNEY ☐ NON-ATTORNEY
PRINT NAME	PRINT NAME
ADDRESS	ADDRESS
(CITY, STATE, ZIP CODE)	(CITY, STATE, ZIP CODE)
TELEPHONE NUMBER ( ) - / FAX NUMBER ( ) -	TELEPHONE NUMBER ( ) - / FAX NUMBER ( ) -

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

8. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

9. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? ☐ Yes ☐ No

10. If "No" checked: (1) attach claimant's explanation for delay; and
(2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

11. Check one:
☐ Initial Entitlement
☐ Termination or other

APPEALS COUNCIL
OFFICE OF DISABILITY ADJUDICATION AND REVIEW, SSA
5107 Leesburg Pike
FALLS CHURCH, VA 22041 - 3255

12. Check all claim types that apply :

☐ Retirement or survivors	(RSI)
☐ Disability-Worker	(DIWC)
☐ Disability-Widow(er)	(DIWW)
☐ Disability-Child	(DIWC)
☐ SSI Aged	(SSIA)
☐ SSI Blind	(SSIB)
☐ SSI Disability	(SSID)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: _____	

PAPERWORK/PRIVACY ACT NOTICE

The Social Security Act (sections 205(a), 702, 1631(e)(1)(a) and (b), and 1869(b)(1) and (c), and Public Law 106-169 (Section 809(a)(1) of Sections 251(a)) as appropriate) authorizes the collection of information on this form. We need the information to continue processing your claim. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration. We explain, in the Federal Register, these and other reasons why we may use or give out information about you. If you would like more information, get in touch with any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995 . You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to : SSA , 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Information About Driver Safety Administrative Hearings

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What is an administrative hearing?

In most circumstances where DMV orders a discretionary action against a person's driving privilege, that person has the right to a hearing before the department to contest the action and review the evidence supporting it. (A discretionary action is one where the law permits, but does not require, DMV to order an action). A person must request a hearing within ten days of receiving notice of the action against the driving privilege. The hearing proceedings are tape recorded and are conducted by telephone or in person. The hearing is held before a Driver Safety Hearing Officer of the department.

At the hearing, the driver is informed of the legal grounds for the action, and has the opportunity to review and challenge the evidence of the department, and to present evidence, witnesses and testimony to persuade the department to modify or rescind the action. The rules that control these hearings are found in the Vehicle Code, the Government Code (Administrative Procedures Act) and in various Appellate and Supreme Court rulings. Following the hearing, the Driver Safety Hearing Officer will make a decision to uphold (sustain), modify, or rescind (set aside) the DMV action.

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What are my legal rights at a DMV administrative hearing?

You have the right to be represented by an attorney or other representative, at your own expense. Representation by an attorney is not required. You have the right to review the evidence and to cross examine the testimony of any witnesses for the department, and to present evidence and witnesses on your own behalf, as well as the right to testify on your own behalf.

Following the hearing, you have the right to be provided a decision in writing. Should the decision resulting from the hearing be against you, you have the right to request the department to conduct an administrative review of the decision, as well as the right to appeal the decision to superior court.

On or after January 1, 2003, new legislation authorizes DMV to collect a $120 fee for a Departmental Review following an Administrative Per Se (APS) hearing pursuant to Vehicle Code §§13353 and 13353.2. Questions regarding this fee should be directed to the Driver Safety office where your hearing was conducted.

Requests for the administrative review or to appeal the decision in court must be made within a certain time period dependent on the type of hearing and as described in the Vehicle Code. These time periods and other specific information concerning your rights will be stated on the notice containing the hearing decision.

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How do I schedule a hearing?

Check the notice you received advising you of the action against your driving privilege. If the notice indicates you have the right to a hearing, you have ten days following receipt of the notice to request a hearing.

You may do so by writing to or telephoning one of the department's Driver Safety Branch Offices. Be sure to identify yourself by your full name, your driver license number, and your date of birth. You will also be asked to verify your correct mailing address.

What if I need an interpreter?

If you or a witness require a sign or language interpreter, immediately contact the Driver Safety Branch Office to request that an interpreter be provided for the hearing.

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What if I do not appear at the hearing?

If you request a hearing and do not attend the hearing, the department will proceed with the case against you.

Will the hearing location be accessible to persons with disabilities?

Hearing locations are accessible to persons with disabilities. However, you should check with the department in advance to assure accessibility.

In addition, if you know persons who plan to attend who have special needs that require reasonable accommodation, please contact the department as soon as possible, so that arrangements can be made.

Click on Driver Safety Branch Offices for a listing of locations.

Driver Safety Offices by Location

To find out on which holidays DMV offices will be closed, check "Holidays DMV Will Be Observing"

The maps to field offices are provided by "Google Maps." The products and services advertised are not promoted or endorsed by DMV.

NOTE: These offices do not provide basic driver licensing or vehicle registration services. Please go to DMV Field Offices for more information on these services.

Bakersfield

- Address
  5800 District Blvd., Ste. 100-B, 93313-2148
- General Information or to Make an Appointment
  Phone (661) 833-2103
  Fax (661) 833-2102

Directions to this Office

- Disabled Parking and Building Access Bakersfield Site Layout | Bakersfield Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

City of Commerce

- Address
  5801 E. Slauson Avenue, Suite 250, 90040-3050
- General Information or to Make an Appointment
  Phone (323) 724-4000
  Fax (323) 724-9262

Directions to this Office

- Disabled Parking and Building Access City of Commerce Site Layout | City of Commerce Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Covina

- Address
  1365 N. Grand Ave., Suite 101, 91724-4048
- General Information or to Make an Appointment
  Phone (626) 974-7137
  Fax (626) 974-7118

Directions to this Office

- Disabled Parking and Building Access Covina Site Layout | Covina Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

El Segundo

- Address
  390 N. Sepulveda Blvd, Suite 2075, 90245-4470
- General Information or to Make an Appointment
  Phone (310) 615-3500
  Fax (310) 615-3581

Directions to this Office

- Disabled Parking and Building Access El Segundo Site Layout | El Segundo Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Fresno

- Address
  2510 S. East Avenue, Suite 310, 93706-5112
- General Information or to Make an Appointment
  Phone (559) 445-6399
  Fax (559) 445-6379 or 445-6396

Directions to this Office

- Disabled Parking and Building Access Fresno Site Layout | Fresno Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Irvine

- Address
  16735 Von Karman, #110, 92606-4953
- General Information or to Make an Appointment
  Phone (949) 440-4416
  Fax (949) 440-4424

Directions to this Office

- Disabled Parking and Building Access Irvine Site Layout | Irvine Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Oakland

- Address
  7677 Oakport St. Suite #220, 94621
- General Information or to Make an Appointment
  Phone (510) 563-8900
  Fax (510) 563-8950

Directions to this Office

- Disabled Parking and Building Access Oakland Site Layout | Oakland Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Oxnard

- Address
  2051 North Solar Drive, Suite 100., 93036-2650
- General Information or to Make an Appointment
  Phone (805) 485-0843

Fax (805) 988-1420

Directions to this Office

- Oxnard Site Layout | Oxnard Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Redding

- Address
  2650 Churn Creek Road, Suite 200, 96002-1169
- General Information or to Make an Appointment
  Phone (530) 224-4755
  Fax (530) 224-4737

Directions to this Office

- Disabled Parking and Building Access Redding Site Layout | Redding Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Sacramento

- Address
  4700 Broadway, 2nd Floor, 95820-1501
- General Information or to Make an Appointment
  Phone (916) 227-2970
  Fax (916) 227-2901

Directions to this Office

- Disabled Parking and Building Access Sacramento Site Layout | Sacramento Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

San Bernardino

- Address
  1845 Business Center Dr., Ste. 212, 92408-3447
- General Information or to Make an Appointment
  Phone (909) 383-7413
  Fax (909) 383-7439

Directions to this Office

- Disabled Parking and Building Access San Bernardino Site Layout | San Bernardino Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

San Diego

- Address
  9174 Sky Park Court, Suite 200, 92123-2666
- General Information or to Make an Appointment
  Phone (858) 627-3901
  Fax (858) 627-3925

Directions to this Office

- Disabled Parking and Building Access San Diego Site Layout | San Diego Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

San Francisco

- Address
  1377 Fell St., 2nd Floor, 94117-2296
- General Information or to Make an Appointment
  Phone (415) 557-1170
  Fax (415) 557-7375

Directions to this Office

- Disabled Parking and Building Access San Francisco Site Layout | San Francisco Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

San Jose

- Address
  90 Great Oaks Blvd, Suite 104, 95119
- General Information or to Make an Appointment
  Phone (408) 229-7100
  Fax (408) 229-7128 or 229-7129

Directions to this Office

- Disabled Parking and Building Access San Jose Site Layout | San Jose Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Van Nuys

- Address
  6150 Van Nuys Blvd., Suite 205, 91401-3333
- General Information or to Make an Appointment
  Phone (818) 376-4217
  Fax (818) 376-4215

Directions to this Office

- Disabled Parking and Building Access Van Nuys Site Layout | Van Nuys Directions

Days and Hours Open

Monday, Tuesday, Thursday, and Friday 8:00am till 5:00pm.

Wednesday 9:00am till 5:00pm

Administrative Hearings

Administrative Hearings

Introduction

Administrative Hearings conducted by the Department of Motor Vehicles (DMV) provide a fair resolution of matters in a professional, efficient way, and ensure due process is afforded to all drivers. This information is a general guide for those entitled to request a Driver Safety (DS) administrative hearing. It is intended to assist you with understanding the hearing process and preparing for your hearing. If you have received notification that a proposed action is being taken against your driving privilege, you must request a hearing within **10 days** of receiving personal service or **14 days** from the date the notice is mailed. If you do not make a timely request, your right to a hearing will be lost.

Not all hearings are the same and this guide may not provide you with all of the necessary information you may need in preparing for your individual hearing. If you have any questions regarding how a hearing is conducted, contact any of the DS offices listed in this publication.

Note: Hearings for drivers who have a certificate to transport passengers may not be conducted in the same manner as described in this publication.

Remember: Carefully read all of the documents that are personally provided or mailed to you by DMV. These documents tell you the issues involved in your case, what deadlines you must meet and your rights that apply in the administrative hearing process. The hearing will be limited to those issues listed in the documents.

Why Do I Need A Hearing With DMV?

The purpose of the hearing is to provide you with an opportunity to be heard and to present relevant evidence or testimony on your behalf regarding an action taken or the intent to take action against your driving privilege by DMV. You may also have to appear in court for the same reason DMV is taking action against your driving privilege. Any action taken by the court is independent of any action taken by DMV.

What Are My Hearing Rights?

You have the right to:

- Be represented by an attorney or other representative, at your own expense.
  — Representation by an attorney is not required.
- Review the evidence and cross examine the testimony of any witness for DMV.
  — DMV can base its case only on written documents without presenting any witnesses. If you wish to question someone who either prepared a document, or someone who is listed on a document that will be used as evidence, it is your responsibility to subpoena that person.
- Present evidence and relevant witnesses on your own behalf.
- Testify on your own behalf.

How Do I Review DMV's Evidence Against Me?

Your verbal or written request to review and obtain a copy of DMV's evidence regarding your case (known as *discovery*) prior to your hearing must be submitted to DMV at least **10 days** prior to the date of your hearing. In some cases, DMV will automatically provide you with this information (*discovery*). If you do not request a hearing, you are giving up your right to review the evidence DMV will consider when making a decision in your case.

How Do I Obtain Records From Agencies or Have Witnesses Come To The Hearing?

You have the right to subpoena relevant records or other documents, photos, etc. to be produced on your behalf at the hearing.

Although your witness(es) may voluntarily attend your hearing, a subpoena protects your right under the law to compel the attendance of any witness. For any witness you subpoena on your behalf, you are required to pay all witness fees and any mileage to the hearing location. If you know a witness requires special accommodation, please contact DMV as soon as possible.

Note: Subpoenas are available online at www.dmv.ca.gov/forms/formsds.htm or at any DS Office. Someone other than you must serve the subpoenas.

What Kind of Evidence Can I Provide on My Behalf?

Any evidence you present must be relevant to your case. Evidence can be presented in the form of sworn documents, medical records, accident reports, photographs, or other relevant items. Evidence can also be sworn testimony taken under oath. On the date of your hearing, be prepared to bring any witness, or written evidence from any witness, who knows the specific issues involved in your case. Your witness(es) should be prepared to answer any questions raised by the hearing officer.

Note: Any evidence presented on your behalf cannot be returned to you because it becomes part of the official administrative hearing record maintained by DMV.

What If I Need an Interpreter?

If you or a witness needs a sign or language interpreter, immediately contact DMV in order to make arrangements for an interpreter.

What If I Cannot Attend My Hearing or I Fail To Show Up?

If you cannot attend your hearing on the scheduled date and time, you must contact DMV prior to the hearing, within 10 working days of the time you know, or should have known, you need a continuance. You may have to file a written statement indicating the reasons you cannot appear. DMV will grant the continuance after **10 working days** if you are not responsible for causing the delay and made a good faith attempt to prevent the delay. If a continuance has not been granted and you do not attend your hearing, DMV will proceed with the hearing in your absence.

How and When Will I Be Notified of The Decision?

You will be notified in writing of the hearing officer's decision even if you do not attend your hearing. The time it takes to make a decision depends on the issues being addressed, the amount of evidence presented, and the testimony presented by any witness.

Can I Appeal DMV's Decision?

If you disagree with the hearing officer's decision, you may have the right to request a department review of the decision, as well as the right to appeal the decision to superior court. Requests for a department review, or an appeal of the decision in superior court must be made within a certain time period depending on the laws affecting your case. The time periods for appeal and other specific information concerning your appeal rights are provided on the notice advising you of the hearing decision.

What Type of Decision Can Be Made?

Depending on the type of hearing, a hearing officer may sustain (*keep in effect*), set aside (*dismiss*), end, or modify DMV's earlier decision. If a time period for an action against your driving privilege is specified in the California Vehicle Code (CVC), the hearing officer cannot change the length of the action.

Note: The Administrative Procedures Act (APA), found in California Government Code Sections 11400 through 11528, and CVC Sections 14100 through 14112, govern DS hearings conducted by DMV. The DS Disciplinary Guidelines can be found in the California Code of Regulations, Section 110.4. The CVC can be found on the DMV website at www.dmv.ca.gov. Copies of the APA, CVC, DS Disciplinary Guidelines, and subpoenas are available from DS Branch Offices.

Contact DMV Driver Safety Offices for Driver Safety Office information, locations and hours.

FFDL 26 (REV 2/2010)

Office of Administrative Hearings Forms

See General Jurisdiction Division Forms for more information
See Special Education Division Forms for more information
See Department of Developmental Services Hearings Forms for more information
See Public Works Contract Arbitration Program Forms for more information
See Teacher Reduction in Force Proceedings Forms for more information

Representing Yourself in a APA Hearing

So...
You're thinking about representing yourself...

What is the Office of Administrative Hearings (OAH)?

The Office of Administrative Hearings is an independent hearing tribunal established by the Legislature to implement the Administrative Procedure Act (APA), found in California Government Code section 11500 and following. These laws, and OAH Regulations (Title 1 of the California Code of Regulations, section 1000 and following) set forth the procedures for most OAH hearings. The California Code of Regulations, the Government Code and most statutes can be found in public libraries or on the internet (http://ccr.oal.ca.gov/ and http://www.leginfo.ca.gov/, respectively). Copies of the APA and subpoenas, including large print subpoenas, are available from OAH.

The Office of Administrative Hearings (OAH) is providing this page to help you prepare for your administrative hearing. This page is not a substitute for having an attorney. It is a guide for you. The information refers to the most common kinds of cases that come before OAH. However, not all cases are the same, and yours may be different. We cannot tell you about all possible situations that might arise. But we hope this page will help you better understand the process and prepare.

What Will My Hearing Be Like?

Your hearing will be very similar to a trial in court, with witnesses, exhibits and rules of evidence. An Administrative Law Judge will preside. The judge is not employed by the agency bringing this action, but by OAH. Normally an attorney represents the agency bringing the action. You may be represented by an attorney, but if you are, you must pay for your own attorney. You may choose to represent yourself. However, an attorney may be better able to present your side.

When the hearing begins, each side may present an opening statement. This tells the judge what that side intends to prove. Each side can then offer relevant evidence to prove its case.

Evidence can be testimony taken under oath at the hearing or it can be certain kinds of documents, such as business records. You must prove that the documents you submit are authentic.

The agency usually presents its evidence first. The agency attorney will ask its witness questions (direct examination). When the attorney is finished, it will be your turn to ask questions of that witness (cross-examination). The agency attorney will have a second chance to ask questions (redirect) and then you will have a second chance (recross).

After the agency has presented its witnesses, it will be your turn. You may make a statement yourself and call your

witnesses. As you finish with each of your witnesses (and your testimony), the agency attorney will cross-examine. As stated before, you will have a second chance to ask questions of each witness. Even if you choose not to testify, the agency attorney may cross-examine you.

After you have presented your case, the agency may call rebuttal witnesses. Rebuttal witnesses may only testify to issues you brought up in your case. If the agency calls rebuttal witnesses, you may be allowed to call additional witnesses to address the issues discussed by rebuttal witnesses. Few hearings involve rebuttal witnesses.

Remember: Before the hearing closes, you must submit all the evidence you want the judge to consider.

After all testimony has been heard, each side can make a closing argument. Usually the agency goes first; you go next. The party that goes first has the opportunity to make the last comments.

Closing argument is your chance to sum up the evidence and tell the judge why you should prevail in your case. It can address only those facts brought out in testimony of witnesses or in documents received into evidence. In some cases, the judge may want the parties to submit written, instead of oral, argument. If so, a schedule will be set up to mail the written arguments.

What Do I Need To Prove?

In a Statement of Issues, the burden is on you to prove your side. If you are applying for a license, you must prove you meet the qualifications for that license.

If you already have a license and the agency wants to take disciplinary action against you, generally the agency has the burden of proof. This means that the agency must establish that you violated the laws or regulations charged in an Accusation.

Even when the agency has the burden of proof, you should prepare to offer evidence of your good character and conduct, mitigation, rehabilitation and evidence refuting the charges, as appropriate.

May I See The Agency's Evidence Against Me?

When you receive the Accusation, Statement of Issues or other document setting forth the issues, you will normally find a paper entitled "Request for Discovery" or something similar. That request is from the agency, and it requires you to provide the listed information to the agency attorney. You have the same right to get information from the agency. Simply send the same type of request to the agency attorney. You may also write the agency attorney and ask to see and/or copy the investigative file and any other documents or relevant evidence the agency has regarding your case. You may have to pay for copies. You also have a right to receive a witness list.

Generally, you must request "discovery" within 30 days of receiving the initial Accusation or Statement of Issues, or within 15 days of any supplemental Accusations or Statements of Issues. In some cases, these times may be shorter. Be sure to read the documents you receive to verify the time you have to request discovery.

What Kind of Evidence Will I Need For the Hearing?

Depending on your case, you may want to bring witnesses who know about the issues involved with the charges against you. If there are documents, such as contracts, business records or checks that help prove your side, try to bring the original and two copies. You may bring photographs or other items that are relevant to your defense. Items you want to be considered must be left with the judge. Generally, you may substitute copies of those items in place of the originals.

How Do I Get Records From a Business?

If you are a party to a hearing, you have the right to subpoena from individuals, businesses and government agencies relevant records or other things to be produced at the hearing. Contact OAH well ahead of the hearing for subpoena duces tecum forms. You must arrange to pay required fees and have someone else serve the subpoenas. See also California Code of Civil Procedure, sections 1985-1985.4 for other important information.

How Do I Get a Witness to Come to the Hearing?

A witness can come voluntarily to the hearing. However, a subpoena protects your right to have that person present. Contact OAH well ahead of the hearing for subpoena forms to compel the attendance of persons whose testimony is relevant to your case. You must arrange to pay required fees and have someone else serve the subpoenas.

Is It OK to Bring Letters Instead of Witnesses?

Some letters and other documents may be admitted in evidence for limited purposes, but generally it is better to bring witnesses who can help present your side of the case and answer any questions raised. The judge will not speak with witnesses, except at the hearing itself. If you do choose to offer letters, declarations or other documents, make sure you check the Administrative Procedure Act first to understand what you must do to get them admitted in evidence.

Remember: This hearing is your chance to tell the judge your side. It is important to have your witnesses present at the hearing to testify.

If I Forget Something, Can I Send It Later to the Judge?

Your chance to present evidence is at the hearing. Only in rare cases will the judge allow you to send evidence later.

Is There a Way To Settle This Without a Hearing?

Informal Hearing / Mediation / Settlement Conferences
Cases often settle without going to hearing. Contact the agency attorney to see if you can work something out. You may also contact OAH for possible assistance, including requesting mediation. In lengthy and complex cases, OAH requires a settlement conference. You will receive a notice to attend a settlement conference, if required in your case.

What If I Can't Be There On The Day Set?

You must show good cause to change a hearing date. If you cannot attend on the date and at the time shown, you must contact OAH as soon as you know of the problem. To request a change of date, you must file a written statement, with a copy to the agency attorney, explaining the reasons for the change. The sooner you make your request, the more likely it will be granted.

Remember: You must file a timely Notice of Defense in order to have a hearing.

What If I Don't Attend?

If you request a hearing and do not attend the hearing, the agency can still proceed with the case against you. (If you do not request a hearing, the agency most likely will proceed against you in your absence.)

What If I Need An Interpreter?

If you or a witness need a sign or language interpreter, immediately contact the agency attorney or OAH so that a certified interpreter can be provided. Normally, it is not sufficient to bring a friend or relative to interpret for you.

Will The Hearing Location Be Accessible To People With Disabilities?

Hearing locations are to be accessible to persons with disabilities. However, check in advance with OAH to assure accessibility. In addition, if you know persons who plan to attend have special needs that require reasonable accommodation, please contact OAH as soon as possible, so arrangements can be made.

The Office of Administrative Hearings complies with the Americans with Disabilities Act. Alternative formats for this pamphlet will be made available to those requesting it.

The Lanterman Act Fair Hearing Process by the State of California Office of Administrative Hearings (OAH)

The Purpose of a Hearing

Through regional centers and other agencies, the State of California provides valuable services to people with developmental disabilities. These services are coordinated by the state Department of Developmental Services and authorized by the Lanterman Developmental Disabilities Services Act (Act). To qualify for state funding, a regional center or developmental center (also called a service agency) must ensure that its decisions are fair and in the recipient's best interest. When a recipient is dissatisfied with a center's decision, the Act permits the recipient to file a request for a fair hearing.

If you are a recipient of state developmental disability services, then this information sheet can give you an overview of what to expect from the fair hearing process. This information sheet is also meant for an authorized representative of the recipient, such as a parent, guardian or attorney.

A hearing is a presentation made by you and the regional center in front of an Administrative Law Judge (ALJ). The ALJ is not an employee of the regional center or Department of Developmental Services, but an impartial judge. The hearing is an opportunity for you to present your arguments, witnesses and other evidence to convince the ALJ that your position is the right one. The regional center also has the opportunity to present its position. Based on arguments from both sides, the evidence, and the Act, the ALJ will make the final decision.

Scheduling a Hearing

After you receive notice of proposed action, you have 30 days in which to file a hearing request if you disagree with the decision or action. You must state your request in writing or complete a hearing request form from the regional center. After mailing in your written request or form, the regional center will notify you with the hearing date and location.

The fair hearing is held within 50 days of the date your hearing request form was postmarked or received by the regional center, whichever is earlier. Hearings may last a few hours or several days, depending on the issues involved. They are usually held at the regional center. If the date or location is not reasonably convenient for you, you and the regional center may arrange another time or place.

Preparing for Hearing

You and your representative have the right to look at the regional center's file relating to your case prior to the hearing.

Legal Representation

Most families represent themselves in the hearing process. However, you may choose to be represented by an advocate or by an attorney at your own expense. The regional center can give you information about advocacy assistance.

Witnesses and Other Evidence

Evidence is information that you present to the ALJ to prove your case. Evidence can be in the form of documents, reports, or witness testimony under oath. Evidence must be relevant to the matters in dispute. If the evidence is not relevant, reliable or believable, the ALJ may decide that the evidence cannot be admitted or relied upon. Be prepared to explain to the ALJ why the evidence is important to your case.

Although you may present letters or written statements to the ALJ, generally it is more convincing to call witnesses who can help present your information and answer questions. You may either call witnesses to volunteer to come to the hearing, or you may subpoena witnesses to require their attendance at the hearing. The ALJ will not speak to witnesses except at the hearing. Contact the Office of Administrative Hearings (OAH) well before the hearing date to get the subpoena forms.

Certain witnesses, such as expert witnesses like doctors, may demand a fee for testifying at the hearing. These fees are paid by the party calling the witness. Choose your witnesses based on their special or direct knowledge of the matters they will discuss at the hearing. Prepare a list of questions to ask each witness to help you present the background information on your case and to establish their qualifications as knowledgeable witnesses.

OAH Complies with the Americans with Disabilities Act.
Alternative formats of this information sheet will be made available to those requesting it.

Exchanging Documents

At least 5 calendar days before the hearing, you and the regional center must exchange copies of any documents, such as the individual planning document, that you each intend to use at the hearing. Suggestion: Make two additional copies of all documents. You must bring the original and these two copies with you to the hearing. You must also exchange a list of witnesses you intend to call and what you expect them to talk about. At the hearing, the ALJ will decide whether to accept a witness who was not on the list or a document that was not given to the other party before the hearing.

The Hearing Itself

At the beginning of the hearing the ALJ will explain how the hearing will proceed. Feel free to ask any questions about what you are expected to do. The entire hearing will be recorded on audio tape.

Each party may give a short opening statement to tell the ALJ what the party wants and what the issues are in the case. Then, both you and the regional center will present your evidence. For example, if you think the regional center should provide you with a particular service, then you must prove to the ALJ, by witness testimony or other evidence, why you are eligible for that service.

After all evidence has been submitted to the ALJ, each party may make a closing argument, but it is not required. If you make a closing argument, you should summarize the case and discuss what the evidence has shown.

The Decision

A written decision will be mailed to you, usually within 10 days of the date the hearing is concluded. Any decision that is not in your favor will be effective 10 days after you and your authorized representative receive the decision by certified mail. If you or your authorized representative cannot understand English, the written decision will be provided in English and in the language you or your authorized representative understands.

Frequently Asked Questions

Q: *How can I arrange for an interpreter at the hearing or for special accommodations for someone who is disabled?*

A: Immediately contact the regional center or OAH to request a sign or language interpreter at the hearing for you or for a witness. If persons you expect to attend the hearing have special needs that require reasonable accommodation, please contact OAH as soon as possible so arrangements can be made.

Q: *May I try to settle my disagreement with the regional center or agency in a less formal meeting than a hearing?*

A: Yes. Cases often settle without going to a hearing, even after the date for a hearing has been set. You may settle at an informal meeting with the regional center or agency. You may also request mediation. Both of these options are voluntary on your part. If you are not able to resolve the case at an informal meeting or mediation, you still have the right to participate in a fair hearing.

Q: *Is it possible to change the fair hearing date after it has been scheduled?*

A: Yes. Either you or the regional center may ask for the hearing date to be changed. This is called a continuance of the hearing. Only OAH may authorize a continuance and will only do so for good cause. Put your request in writing as soon as you learn of the need for a continuance, and state all the reasons why you need a continuance. Mail or FAX your request to OAH. A copy of your request must be sent to the regional center or agency. If there is not enough time to send a written request, you may request a continuance by telephone. To obtain a continuance, you may have to waive in writing the statutory timelines contained in Welfare and Institutions Code sections 4712 and 4712.5. These timelines include, but are not limited to, the time for scheduling the hearing in the case and the time for rendering a final or proposed decision by the ALJ.

Q: *Where can I get more information about fair hearings related to the Lanterman Developmental Disabilities Services Act?*

A: More information on the Act and related regulations is available at a law library and on the internet. The hearing procedures of the Act are codified in the California Welfare and Institutions Code, Division 4.5, Chapter 7, sections 4700-4731, and may be accessed at http://www.leginfo.ca.gov. Related regulations are published under Title 17 of the California Code of Regulations, Public Health Division 2, Chapter 1, Subchapter 9, and may be accessed at http://ccr.oal.ca.gov/.