

The University of the State of New York
 THE STATE EDUCATION DEPARTMENT
 Office of Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR)
Administrative Review / Mediation / Impartial Hearing Request

VR-711 (rev 01/11)

YOUR NAME LAST	FIRST	MIDDLE INITIAL	PHONE ()	E-MAIL ADDRESS
YOUR ADDRESS STREET (INCLUDE BUILDING AND APT #)		CITY	STATE	ZIP

If you do not agree with a decision made by ACCES-VR, you may ask for a review of the decision through the following ways: **Administrative Review, Mediation, and/or Impartial Hearing.**

I would like the following to be completed within **60 days**

- Administrative Review**
- Mediation**
- Impartial Hearing only, I do not want an Administrative Review or Mediation.**

-OR-

- I agree to delay scheduling the Impartial Hearing until an **Administrative Review** is completed.
- I agree to delay scheduling the Impartial Hearing until **Mediation** is completed.

I understand that I can request an **Administrative Review** and/or **Mediation** first, or instead, go directly to an **Impartial Hearing**. Further information about due process can be found in the brochure "WHAT CAN I DO IF I DISAGREE WITH ACCES-VR DECISION ABOUT MY CASE" and at <http://www.acces.nysed.gov/vr/do/expectations.htm>. Further information about statutes, regulations, and ACCES-VR policy is available at http://www.acces.nysed.gov/vr/current_provider_information/vocational_rehabilitation/policies_procedures/00_0_index.htm or at 1-800-222-5627.

I understand that no matter which option I choose, all timeframes will begin from the date when ACCES-VR receives this signed request. All parties must agree to any extended timeframes.

I understand that I have the right to be represented by a relative, attorney, advocate, or other spokesperson. I have been informed about the availability of the Client Assistance Program (CAP). Further information is located at <http://www.cqc.ny.gov> or 1-800-624-4143 (Voice / TTY).

If you intend to be represented by a relative, an attorney, an advocate, (including a CAP representative) or another person, please complete the following information so that notice of the hearing and other documents can be provided to them.

NAME OF REPRESENTATIVE:	PHONE ()	RELATIONSHIP TO YOU
STREET ADDRESS	CITY	STATE
ZIP	E-MAIL ADDRESS	

What are the issues you would like reviewed? What action would you like from ACCES-VR? As simply as you can, describe the problem, when it happened, and identify the people involved. (Need more space? Use the reverse or attach a page).

Your Signature (required): _____ **Date:** _____

*A request for an **Administrative Review, Mediation, or Impartial Hearing** must be made within 90 days of the action or decision with which you disagree, unless you can show good reason for asking after 90 days.*

District Office:	Date Received:
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