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| PASRR REQUEST FOR RECONSIDERATION |

Complete this requestif you wish to discuss the recommendations included in the Department of Health Care Services (DHCS) PASRR letter. Complete the following and attach a copy of the letter. Send this request to: Department of Health Care Services Clinical Assurance and Administrative Support Division PASRR Section PO Box 997419 MS 4506 Sacramento CA 95899-7419 or FAX it to (916) 319-0980.

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| --- | --- | --- | --- | --- |
| Current Date | Resident’s Name | | | |
|  |  | | | |
| Client Identification Number (CID) | Facility Name and Address | | | |
|  |  | | | |
| Telephone | E-Mail: |  | | |  |
|  |  |  | | |
| I am a:  Resident  Family Member/Conservator/Facility Staff/Other  My name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  My relationship to the resident is:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I would like to speak to someone from the DHCS PASRR Section | |  | The reason for my request is:  I am requesting Reconsideration of the Recommendations in the Determination Letter  There was an error in the Determination Letter  I have another concern I want assistance with | |
| Please describe your request: | | | | |
| What outcome would you like: | | | | |
| Name of Conservator (if one has been appointed by court) | | | | Telephone Number |
| Signature of the Individual Completing the Form | | | | Telephone Number |