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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.

|  |  |
| --- | --- |
| 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  |