Preadmission Screening and Resident Review
Request for Reconsideration Application

To request reconsideration of a PASRR Determination, complete and submit this form with supporting documentation to the California Department of Health Care Services (Department). Required response fields are marked with an asterisk (*).

*1. PASRR Case Identification Number	*2. Applicant or Resident Full Name		
*3. Facility Name	4. Facility Phone Number (area code and number)		
5. Facility Address (number, street)	City	State	Zip code

6. Screening type on Notice of Determination

- ☐ Preadmission Screening (PAS)
- ☐ Resident Review (RR)

7. Court Appointed Conservator, Guardian, or Legal Representative

- ☐ Yes (complete fields 7a and 7b)
- ☐ No (skip to field 8)

7a. Court Appointed Conservator, Guardian, or Legal Representative Full Name	7b. Court Appointed Conservator, Guardian, or Legal Representative Phone Number (area code and number)

*8. Contesting a Determination made by	*9. Reason for contesting Determination
☐ The California Department of Health Care Services (Mental Health Authority) ☐ The California Department of Developmental Services (Intellectual Disability Authority)	☐ Placement ☐ Nursing Facility Services ☐ Specialized Add-on Services ☐ Other concern

*10. Please explain the reason you disagree with the Determination and your desired outcome. Submit supporting documentation to substantiate your request.

Information of Individual Completing the Form		
*11. Relationship to the Applicant/Resident		
☐ Self	☐ Department Staff	☐ Caregiver/Guardian
☐ Facility Staff	☐ Court Appointed Conservator/Legal Representative	
*12. Name		

*13. Phone Number (area code and number)	14. Email Address
*Signature	*Date

How to Submit this Form	
Mail to: **Department of Health Care Services** **Clinical Assurance Division** **PASRR Section** **P.O. Box 997419 Mail Stop 4500** **Sacramento, CA 95899-7419**	Fax to: **(916) 319-0980**

Privacy Statement

The personal, medical, and protected health information collected on and with this form is confidential and subject to the California Department of Health Care Services (Department) Notice of Privacy Practices that can be found here: https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf. The Department needs the information to process your Request for Reconsideration. The Department will not use or share the information for other purposes except with your permission or as permitted by law. You must provide all of the required information on this form. If you do not provide all of the required information, we cannot process your Request for Reconsideration. In most cases, the individual(s) to whom this information pertains has the right to access it. The Department is authorized to collect this information pursuant to Welfare and Institutions Code sections 14043 through 14043.75; section 1919(e)(7) of the Social Security Act (title 42 United States Code section 1396r(e)(7)); California Code of Regulations, title 22, sections 51000 through 51451 and sections 52700 through 52710; and Code of Federal Regulations, title 42, part 483. This privacy notice is required by California Civil Code section 1798.17.