



# DUE PROCESS REQUEST

Form VR-711 (Rev. 7-2014)

This **VR-711 Form** is designed to assist you in filing a due process request. If you do not agree with a decision made by ACCES-VR, you may ask for a review of the decision by requesting an **Administrative Review**, **Mediation** and/or an **Impartial Hearing**. A due process request 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. Failure to provide all required information may result in delay or dismissal of your request. ACCES-VR will send you a notice that identifies your review date.

► **For DO/CO Use** ◀  
 Date stamp form receipt here:

Further information about due process can be found in the ACCES-VR Due Process Rights Brochure available online at [http://www.acces.nysed.gov/vr/quality\\_assurance\\_monitoring/appeals\\_brochure.pdf](http://www.acces.nysed.gov/vr/quality_assurance_monitoring/appeals_brochure.pdf). Additional information about applicable statutes, regulations, and ACCES-VR policy and procedure is available online at <http://www.acces.nysed.gov/vr/do/home.html> or you can call: 1-800-222-5627.

## 1. CONTACT INFORMATION

<b>Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Phone: (    )</b>	<b>Email Address:</b>	

## 2. TYPE OF REVIEW (required)

I am requesting the following review to be completed within **60 days** (check appropriate boxes):

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

MEDIATION  
 I agree to delay scheduling the Impartial Hearing until **Mediation** is completed.

IMPARTIAL HEARING only, I do not want an **Administrative Review** or **Mediation**.

- I understand that I can request an **Administrative Review** and/or **Mediation** first, or instead, go directly to an **Impartial Hearing**.
- I understand that no matter which review option I choose, all timeframes will begin from the date when ACCES-VR receives the completed due process request, including signature, date, description of issue(s) and type of review requested. 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 can be requested by contacting DISABILITY RIGHTS NEW YORK – Phone: (518) 432-7861 (main number); Toll-free: (800) 993-8982; TTY: (518) 512-3448; FAX: (518) 427-6561 or Email: [mail@disabilityrightsny.org](mailto:mail@disabilityrightsny.org).

## 3. WHAT DECISION WOULD YOU LIKE REVIEWED? (required)

Describe (as simply as possible) the problem, when it happened, and identify the people involved. What action would you like from ACCES-VR? (*Need more space? Use back of form or attach another page.*)

## 4. REPRESENTATION

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 the hearing notice and other documents can be provided to them.

<b>Name of Representative:</b>	<b>Relationship to you:</b>	
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Phone: (    )</b>	<b>Email Address:</b>	

## 5. SIGNATURE & DATE (required)

<b>Your Signature:</b>	<b>Date:</b>
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