



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Executive Office of Elder Affairs

Request for Aging Services Access Point Review

To request a review of the Aging Services Access Point's decision, you must complete and return this form within 30 calendar days of when you get the notice of action.

Mail or hand deliver this form to: _____

Please complete all appropriate sections:

1. Name: _____ Telephone no.: _____

Address: _____

City/Town: _____

2. I disagree with the decision made by the ASAP to change my services. I am requesting an appeal of this decision.

Signature: _____ Date: _____

3. I would like (check one):

☐ a telephone review at _____ (telephone number).

☐ an in-person review.

4. I would like to have the following person represent me:

Name: _____

Telephone no.: _____ Relationship: _____

Address: _____ City/Town: _____

You will be notified in writing of the time, date, and location of the Review meeting within seven calendar days of when ASAP gets this form. The Review meeting will be held within 21 calendar days of when the ASAP gets this form.

If you have any questions, please contact your Case Manager at: _____