



Request to Appeal Aging Services Access Point Review Decision

To request an appeal of the ASAP Review decision, you must complete this form, within 30 calendar days of when you get the ASAP Review decision, and return this form to:

Hearing Coordinator
Executive Office of Elder Affairs
One Ashburton Place, Fifth Floor
Boston, MA 02108

1. Name: _____ Telephone no.: _____

Address: _____

City/Town: _____

2. I disagree with the Review decision made by the ASAP because:

I am requesting an appeal of this decision.

Signature: _____ Date: _____

3. I would like (check one):

- ☐ a telephone hearing at _____ (telephone number).
☐ an in-person hearing.

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

Name: _____

Telephone no.: _____ Relationship: _____

Address: _____ City/Town: _____

Elder Affairs will contact you when we get this form. Within 30 calendar days after we receive the form, you will be notified of the time, date, and location of the hearing. You may also submit copies of documents that you plan to use to support your appeal.

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