Office of Child Development and Early Learning Infant/Toddler Program
Due Process Request

A Due Process Hearing Request Form is submitted to the ODR within 3 calendar days from the date of written request. Documentation such as a copy of the IFSP (draft accepted) or evaluation, etc. shall be attached to this form. Submit copies of request to parent(s) and Regional Office. Maintain a file copy in MH/ID Office.

Student Information
Date of Written Request from Parent(s) _________________ Name of Child: ____________________________
Date of Birth: ________________ Gender: M / F Exceptionality: ____________________________

County MH/ID Office Information
County MH/ID Office: ____________________________________________________________
Name of County MH/ID Contact Person: ____________________________________________
Title: __________________________________________________________________________
Address: _________________________________________________________________________
Phone: __________ Cell Phone: __________ Email: ______________ Fax: _______________

County Legal Representative (if applicable)
Name: __________________________________________________________________________
Address: _________________________________________________________________________
Phone: __________ Cell Phone: __________ Email: ______________ Fax: _______________

Schedule Hearing with: □ County MH/ID Contact Person or □ Legal Representative
Parent(s) Name(s): __________________________________________________________________
Address: _________________________________________________________________________
Home Phone: __________ Cell Phone: __________ Work Phone: __________
Email: _________________
Parent Representative Information
Parents’ representative: (Insert the name or “None”) ________________________________

Title: _________________________________________________________________________

Address: ______________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Phone: ___________________ Email: ___________________ Fax: _______________________

Schedule Hearing with: □ Parent(s) or □ Representative

Reason for Hearing: _______________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Time of Hearing:
Preferred: 9:00 am – 12:00 pm 1:00 pm – 4:00 pm 5:00 pm – 7:00 pm

Type of Hearing: Open to the Public Closed (participants only)

Language Preferred by the parents: ________________________________________________

Alternative Mode of Communication: ______________________________________________

County MH/ID Office has provided a site for the hearing accessible for individuals with disabilities at the following address:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please include a Google Maps link to the site of the hearing:

Person completing this form
Name: ______________________________ Email: ________________________________
Phone: ___________________________ Date: ____________________________

Please submit this Form and documentation to:
Office for Dispute Resolution
6340 Flank Drive
Harrisburg PA  17112-2764
Phones:
717-901-2145
800-222-3353 (PA only)
PA Relay 711 (TTY Users)
717-657-5983 (Fax)

10/2019