HEARING SUMMARY

Michigan Department of Community Health

INSTRUCTIONS:

Complete this form and mail it at least **seven (7) calendar days** prior to the scheduled hearing to:

- **ADMINISTRATIVE TRIBUNAL & APPEALS**
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30763
  LANSING MI 48909 **AND**

- **THE CLIENT/BENEFICIARY/PATIENT**

If you have questions, you may call toll free
1 (877) 833-0870

SECTION 1 – Case Information:

Case Name	Case Number	Co.	Dist.	Sect.	Unit	Wkr.

SECTION 2 – Hearing Summary:

1. Effective Date of Action	2. Date Appellant was Notified of Department Action	3. Date Hearing Requested

4. Were Medicaid services continued pending outcome of the hearing?	5. Was Conference Held Prior to Hearing?
☐ **NO** ☐ **YES**	☐ **NO** ☐ **YES**

6. Explanation of Action(s) Taken:

SAMPLE

7. Facts and Fact Sources Used in Taking This Action(s):

8. Law(s), Regulation(s) or Policy Manual Item(s) Used in Taking This Action(s):

SECTION 3 – Signature:

9. Prepared By: (Signature)	10. Date Signed	11. Phone Number

The Department of Community Health is an equal opportunity employer, services and programs provider.	**AUTHORITY:** 42 CFR 431.200 – 431.250 **COMPLETION:** Is Voluntary **CONSEQUENCE**: NONE