

**REQUEST FOR HEARING FOR MEDICAID ENROLLEES,
PACE ENROLLEES OR WAIVER APPLICANTS**

Michigan Office of Administrative Hearings and Rules

Michigan Department of Health and Human Services

PO Box 30763, Lansing, MI 48909

Telephone Number: 800-648-3397 Fax: 517-763-0146

SECTION 1: TO BE COMPLETED BY THE PERSON REQUESTING A HEARING

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|--|-------|----------|------------------------------------|----------------------------|
| Client Name | | | Client Telephone No. | Client Social Security No. |
| Client Address (No. and Street, Apt. No.) | | | | Medicaid ID No. |
| City | State | Zip Code | Client or Legal Guardian Signature | Date |
| What agency took the action or made the decision that you are appealing? Make sure to attach a copy of the letter from the agency that told the client about their decision. | | | | Client MDHHS Case No. |

I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. **Use additional sheets if needed.**

Do you have a physical disability or other condition requiring special arrangements for you to attend or participate in a hearing?

No Yes (If yes, please explain here.)

Will you need an interpreter?

No Yes (If yes, language needed:)

SECTION 2: HAVE YOU CHOSEN SOMEONE TO REPRESENT YOU AT THE HEARING?

Has someone agreed to represent you at this hearing?

No Yes (If Yes, have the representative complete and sign Section 3.)

SECTION 3: AUTHORIZED HEARING REPRESENTATIVE INFORMATION

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|---------------------------------------|------------------------------|--------------------------|-------------|
| Name of Representative (please print) | Representative Telephone No. | Relationship to Enrollee | |
| Address (No. and Street, Apt. No.) | City | State | Zip Code |
| Representative Signature | | | Date Signed |

SECTION 4: AGENCY INVOLVED IN THE ACTION BEING DISPUTED BY THE CLIENT

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| Name of Agency | | | Agency Contact Person Name |
| Agency Address (No. and Street, Apt. No.) | | | Agency Telephone Number |
| City | State | Zip Code | State Program or Service being provided to this client |

REQUEST FOR HEARING FOR MEDICAID ENROLLEES, PACE ENROLLEES OR WAIVER APPLICANTS INSTRUCTIONS

A hearing is an impartial review of a decision made by the Michigan Department of Health and Human Services or one of its contract agencies that a client believes is wrong.

This form is to ask for a hearing if you are a Medicaid enrollee, or a PACE enrollee, or a Medicaid waiver applicant when the action has been taken by MDHHS or one of its contract agencies. You can also send in your signed hearing request in writing on any paper. This form is also available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Office of Administrative Hearings and Rules for the Department of Health and Human Services or www.michigan.gov/LARA >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings.

Do not use this form to appeal an action

- Taken by a Medicaid, Healthy Michigan Plan or MI Health Link health plan, Community Mental Health Services Program / Prepaid Inpatient Hospital Plan (CMHSP/PIHP), Healthy Kids Dental health plan, or MI Choice Waiver Agency. You must go through their internal appeals process first before you ask for a MDHHS-5617-MOHR, Request for State Fair Hearing form. This form is also available online at the links above.
- Related to program eligibility, cash assistance, food assistance, or other assistance programs. Use the DHS-18, Request for Hearing form available online at www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Forms and Applications >> Other, or go to www.michigan.gov/documents/FIA-Pub18_14356_7.pdf to download the form.

GENERAL INSTRUCTIONS

- Read ALL instructions before completing the attached form.
- Complete Section 1 using the name of the client (even if the client has a guardian or is a minor).
- Complete Sections 2 & 3 only if the client wants someone to represent them at the hearing.
- Complete Section 4 if the agency who took the action you are appealing did not fill this out.
- Attach a copy of the notice or letter from the Agency that told the client about the change that is being appealed.
- Please make a copy for your records.
- Questions can be answered by calling toll free: **800-648-3397**.
- After the form is completed, mail or fax page 1 to:

**MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 30763
LANSING MI 48909
Fax 517-763-0146**

- The client may choose to have another person represent them at a hearing.
 - This person can be anyone the client chooses but must be at least 18 years of age.
 - The client must give this person written permission to represent them.
 - The client may give written permission by checking yes in Section 2 and having the person who is representing them complete Section 3. The client must still complete and sign Section 1.
 - The client's guardian or conservator may represent them. A copy of the court order naming the guardian or conservator must be included with this request.

Completion: Is Voluntary.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
 Compliance Office, 4th Floor
 P.O. Box 30195
 Lansing, MI 48909

517-284-1018 (Main), TTY 711, 517-335-6146 (Fax)

You can also file a civil rights complaint with the responsible federal agency.

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| <p>If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at:</p> <p>U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD)</p> <p>Complaint forms are available at https://bit.ly/2IKsHMS.</p> | <p>If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by:</p> <p>Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form.</p> <p>To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410</p> <p>Fax: 202-690-7442; or Email: program.intake@usda.gov</p> |
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MDHHS is an equal opportunity provider.