REQUEST for HEARING

INSTRUCTIONS

You may use this form to request a hearing. You may also submit your hearing request in writing on any paper.

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

GENERAL INSTRUCTIONS:

- Read ALL instructions FIRST, then remove this instruction sheet before completing the form.
- Complete **Section 1**.
- Complete **Section 2** only if you want someone to represent you at the hearing.
- **Do NOT** complete Section 4.
- Please use a PEN and PRINT FIRMLY.
- If you have any questions, please call toll free: **1 (877) 833 - 0870**.
- Remove the BOTTOM (**Yellow**) copy and save with the instruction sheet for your records.
- After you complete this form, mail it in the enclosed self addressed, postage paid envelope or mail to:

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763
LANSING MI 48909

- You may choose to have another person represent you at a hearing.
- This person can be anyone you choose but he/she must be at least 18 years of age.
- You MUST give this person written permission to represent you.
- You may give written permission by checking **YES** in **SECTION 2 and having the person who is representing you complete SECTION 3**. **You MUST still complete and sign SECTION 1.**
- Your guardian or conservator may represent you. A copy of the Court Order naming the guardian/conservator must be included with this request.

- The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.
- If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Department of Community Health.

Authority: MCL 330.1236; MCL 330.1238; MCL 330.1407; MCL 333.5451; MCL 400.9; 42 CFR 431.200 *et. seq.*; 42 CFR 438 *et. seq;* 7 CFR 246.18; MAC R 325.910, *et.seq*.; MAC R 330.4011; MAC R 330.5011; MAC R 330.8005, *et. seq*.; MAC R 400.3401, *et.seq*.;

Completion: Is Voluntary

If you do not understand this, call the Department of Community Health at (877) 833-0870.
Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.
إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية ميتشيجن.

1 (877) 833 - 0870

See the Request Form Underneath

REQUEST FOR HEARING

Michigan Department of Community Health

IMPORTANT:

- Read the instruction sheet first.
- See the instruction sheet for **non-discrimination** and **PA 431** information.

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763
LANSING MI 48909 **1 (877) 833-0870**

SECTION 1 – To be completed by PERSON REQUESTING A HEARING:

Your Name			Your Telephone Number ( )	Your Social Security Number
Your Address (No. & Street, Apt. No., etc.)			Your Signature	Date Signed
City	State	ZIP Code		
What **Agency** took the action or made the decision that you are appealing.			Case Number	

I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. ***Use Additional Sheets if Needed.***

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

☐ **NO**

☐ **YES** (Please Explain in **Here**):

SECTION 2 – Have you chosen someone to represent you at the hearing?

Has someone agreed to represent you at a hearing?

☐ **NO** ☐ **YES** (If YES, have the individual complete the information below)

SECTION 3 – Authorized Hearing Representative Information:

Name of Representative			Representative Telephone Number ( )	
Address (No. & Street, Apt. No., etc.)			Representative Signature	Date Signed
City	State	ZIP Code		

SECTION 4 – To be completed by the AGENCY distributing this form to the client

Name of Agency			AGENCY Contact Person Name
AGENCY Address (No. & Street, Apt. No., etc.)			AGENCY Telephone Number ( )
City	State	ZIP Code	State Program or Service being provided to this appellant