

BARRY V. LYON LAWSUIT

**HEARING REQUEST
FOR CASH ASSISTANCE or CHILD CARE BENEFITS
(SDA, FIP, RAP, or CDC)**

Please fill in all information. Please print clearly. (*Denotes a required field.)

- If information that has been pre-printed is not correct, please write in the corrected information.
- Be sure to SIGN THE FORM and keep a copy of this form with the date that you mail it.
- Mail this form to: Michigan Department of Health and Human Services
Barry Lawsuit Processing Unit
PO Box 30784
Lansing MI 48909-9561

If you received this form with a letter addressed to you, use the enclosed, self-addressed, stamped envelope.

SECTION 1 – Person Requesting Hearing

*First Name		*Mid. Initial	*Last Name		Phone number () -
MDHHS Case Number (if known)		Date of Birth (M, D, Year)	Social Security Number XXX-XX-		
*Street Address or PO Box	*City	*County	*State	*Zip	
Email Address			What is the primary language spoken in your home?		
<p>I received a notice denying or cutting off my benefits because of a “criminal justice disqualification.” I request a hearing on that denial or termination. The benefits I lost were (check all that apply):</p> <p><input type="checkbox"/> Cash Assistance (FIP, SDA, or RAP)</p> <p><input type="checkbox"/> Child Day Care Assistance (CDC)</p> <p>I believe that MDHHS action was erroneous and unlawful.</p>					

SECTION 2 – Representation

<p>Has someone agreed to represent you at a hearing?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, have the individual complete and sign section 3).</p>
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SECTION 3 – Authorized Hearing Representative Information

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

My signature means the information on this form is true.

*Signature	*Date
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Keep a copy of this form for your records. Write the date you mail this form on your copy.

Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, 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 an MDHHS office in your area.