



...enhancing the lives of children with special needs in Michigan

Michigan Department of Health and Human Services  
Children with Special Needs Fund  
PO Box 30734  
Lansing, MI 48909  
Phone: (517) 241-7420  
Fax: (517) 335-8055  
[www.michigan.gov/csnfund](http://www.michigan.gov/csnfund)

## CSN Fund Application Guidelines

**What does the CSN Fund do?** The Children with Special Needs Fund (CSN Fund) provides financial assistance to children with special health care needs to purchase equipment when no other funding source is available, including state or federal programs. The CSN Fund is comprised entirely of donations and is administered through the Michigan Department of Health and Human Services (MDHHS), Children's Special Health Care Services (CSHCS) Division.

### What items/equipment does the CSN Fund cover?

- ❖ Adaptive Recreational Equipment
- ❖ Air Conditioners/Central Air
- ❖ Ceiling Lifts or Stair Lifts\*
- ❖ Electrical Service Upgrades
- ❖ Platform Lifts (when wheelchair ramp cannot be installed ADA-compliant)
- ❖ Therapeutic Specialty Bikes/Tricycles
- ❖ Transit Options
- ❖ Turney Seats
- ❖ Vehicle Accessibility Devices (van lifts, ramps, restraint systems, tie downs, etc.)
- ❖ Weighted Blankets/Vests
- ❖ Wheelchair Ramps (residential)

*\*These items are contingent on availability of a special grant. Call the CSN Fund to find out if funding is available. Requests for items not listed above may be reviewed by the CSN Fund Advisory Committee.*

**Who is eligible to apply to the CSN Fund?** Families with a child under the age of 21, who is enrolled or medically eligible to enroll, in the Children's Special Health Care Services (CSHCS) Program may apply for assistance for an item related to a CSHCS diagnosis. To find out if your child is eligible, contact the CSHCS office at your local health department.

Children enrolled in Adoption Medical Subsidy, Habilitation Support Waiver, Community Mental Health, or have a Trust/Insurance Settlement must apply to these sources FIRST before contacting the CSN Fund. The CSN Fund is the payor of last resort. Children covered by the Children's Waiver are **NOT** eligible for assistance from the CSN Fund.

#### Your Local Health Department Can Help

CSHCS staff at the local health department can assist with the application process, locating nearby vendors, and finding local agencies who may be able to help. Your local CSHCS staff may not gather the estimates for equipment on your behalf. Call your local health department or the CSHCS Family phone line at 1-800-359-3722.

**What are the medical eligibility criteria?** Children under age 21 and enrolled in, or medically-eligible to enroll in, CSHCS are eligible to apply for assistance from the CSN Fund for an item related to the CSHCS-qualifying diagnosis.

**What are the income eligibility criteria?** If the child is not currently enrolled in CSHCS, the financial assessment form (DCH-1273) must be submitted with the application or the request cannot be processed.

**Does the CSN Fund reimburse for equipment or services?** No, the CSN Fund will not reimburse a family, business, or funding source for equipment already provided or purchased.

## Amount of Assistance Provided

The CSN Fund grants funding to families based on the following limits and/or restrictions.

Equipment	Limit	Exclusions/Restrictions	Maximum Assistance
Adaptive Recreational Equipment	No limit	No duplicate requests within 5 years	\$1,500
Air Conditioners/Central Air <sup>1</sup>	One (1) per family	Portable units only for rental units	\$550
Ceiling/Stair Lifts <sup>2</sup>	One (1) per family	Not allowed for rental units. Based on availability of special grant funds	TBD <sup>4</sup>
Electrical Upgrades	One (1) per family		\$1,000
Platform Lift <sup>3</sup>	One (1) per family	Only when wheelchair ramp is not able to be installed ADA-compliant	\$4,000
Tie Downs	No limit; replaced as needed.		\$1,000
Transit Options	Up to two (2) per child. Second request considered for wheelchair replacement.	Must provide invoice with actual cost detail (not MSRP)	TBD <sup>4</sup>
Tricycle	Every 2-5 years		\$2,300
Vehicle Accessibility Devices	Up to two (2) per family. Second request > 5 years after first request.		\$10,000
Weighted Blankets, Vests	Up to two (2) per child. Second request > 5 years after first request.		\$200
Wheelchair Ramps	One (1) per family per lifetime		\$4,000

<sup>1</sup>Air conditioner units are ordered directly from distributor and do not require 3 bids.

<sup>2</sup> Stair/Ceiling lifts are contingent on availability of special grant funding.

<sup>3</sup> Platform lift is allowed only when documented that wheelchair ramp cannot be built to meet ADA guidelines.

<sup>4</sup>Maximum assistance for certain items are "To Be Determined" on a case-by-case basis.

## Decisions

While it is our mission to help as many children as possible, not all requests can be granted. **PLEASE ALLOW FOUR TO SIX WEEKS FOR ROUTINE DECISIONS TO BE MADE.** Urgent requests should be indicated in your letter. Some requests may be reviewed by the CSN Fund Advisory Committee and require additional time for decisions to be made. Once a decision is made a letter will be mailed to you. Funding is from private donations, not by state or federal funds, therefore all decisions are final, and there is no appeal process.

**Applications are available at your local health department, the website [www.michigan.gov/csnfund](http://www.michigan.gov/csnfund), or through the CSN Fund office. Contact the CSN Fund at (517) 241-7420 or toll free at (800) 359-3722 with any questions. Surveys will be mailed to beneficiary after service/equipment has been paid by the CSN Fund.**

### **SUBMIT APPLICATIONS TO:**

Children with Special Needs Fund  
Michigan Department of Health and Human Services  
PO Box 30734  
Lansing, MI 48909

**OR**

Fax: (517) 335-8055 **OR** Email: [csnfund@michigan.gov](mailto:csnfund@michigan.gov)

## Guidelines for CSN Fund Coverage Categories

*\*\* Families with more than one (1) eligible child may be given special consideration to determine the amount of funding.\*\**

### Adaptive Recreational Equipment

- ❖ The CSN Fund will provide up to \$1,500 for recreational equipment including, but not limited to, floatation devices, swings, and bike trailers. Requests will be reviewed on a case-by-case basis.

### Air Conditioners/Central Air installation

- ❖ The CSN Fund may contribute a maximum of \$550 towards a room air conditioner/central air installation. Indicate on the application if you prefer a window unit or portable unit.
- ❖ The CSN Fund may approve one (1) air conditioner/central air installation request per family.
- ❖ No quotes are required for portable or window air conditioners (these are ordered directly from distributor).
- ❖ One (1) bid/quote for central air requests (if the family owns the home).
- ❖ Approval for this request is contingent on a CSN Fund qualifying diagnosis.
- ❖ Requests for funding for Central Air in rental properties will not be approved.

### Ceiling Lifts & Stair Lifts

- ❖ Approval for stair and ceiling lifts is contingent upon availability of funds. Contact the CSN Fund to find out if funds are available.
- ❖ This equipment will not be approved for a rental unit.
- ❖ Only one (1) can be granted per family.
- ❖ Three (3) bids/quotes with installation diagrams are required. The CSN Fund will only pay up to the amount of the lowest bid received.

### Electrical Service Upgrades

- ❖ The CSN Fund may pay a maximum of \$1,000 towards installing a dedicated circuit for the safe operation and function of medical equipment at home.
- ❖ A signed landlord agreement (Form DCH-2424) must be included for those living in a rental property.
- ❖ Two (2) bids/quotes for electrical service requests are required.

### Platform Lift (see Wheelchair Ramps)

### Therapeutic bikes/tricycles

- ❖ The CSN Fund may pay a maximum of \$2,300 towards a therapeutic bike/tricycle.
- ❖ A new bike may be approved two to five years after the previous request was approved.
- ❖ Rifton Order Form DCH-1342 must be completed by a licensed medical therapist (OT or PT) who will determine the appropriate level of equipment and provide medical justification for the equipment.
- ❖ Rifton tricycle requests do not require quotes.
- ❖ AMBUCS Amtryke tricycles require one (1) quote. Visit <https://www.ambucs.org/join/chapter-directory/> to find the chapter closest to you. Some chapters require specific forms to be completed. If this is the case, please include these Amtryke forms with your CSN Fund application.
- ❖ All other therapeutic tricycle requests must also include an evaluation by a licensed medical therapist (OT or PT) to indicate the appropriate type of equipment and medical justification for the equipment.

### Transit Options

- ❖ The CSN Fund may cover costs of adding a transit option to a wheelchair when this option is not covered by insurance. Requests will be reviewed on a case-by-case basis. Only one transit option will be approved per child. A second request may be considered if the child's wheelchair has been replaced. Three (3) bids are not required but the vendor must provide an itemized quote listing each component with retail and dealer/vendor prices.

## Vehicle Accessibility Devices (i.e., van lift/ramp, tie-downs, wheelchair lifter, assistive seating/Turney Seat, reverse swing doors, restraint systems)

- ❖ The CSN Fund may pay or contribute a maximum of \$10,000 towards a vehicle accessibility device.
- ❖ The CSN Fund may contribute towards the replacement cost of a tie-down system.
- ❖ It is highly recommended for your child to accompany you to the vendor, if possible, so that you can get the quote for the appropriate lift system.
- ❖ The CSN Fund may approve a maximum of two (2) vehicle accessibility devices per child per lifetime. The second item will only be considered five (5) years after the first item was approved.
- ❖ 3 quotes from different vendors are required. Quotes must be itemized with cost of vehicle (if purchasing a vehicle), conversion, lift, tie downs, and other components. The CSN Fund will only pay up to the amount of the lowest bid received.

## Weighted Blankets, Vests

- ❖ The CSN Fund may pay a maximum of \$200 toward the purchase of a weighted blanket or vest.
- ❖ Three (3) bids/quotes for weighted blankets or vests are required.
- ❖ A second request may be submitted after five (5) years have elapsed since the first blanket/vest was approved.

## Wheelchair Ramps

- ❖ The CSN Fund may pay a maximum of \$4,000 towards a wheelchair ramp or platform lift for eligible children.
- ❖ The CSN Fund may approve one (1) ramp per family. However, if there are unusual circumstances, consideration may be given for a second ramp.
- ❖ All ramps funded by the CSN Fund are expected to meet Americans with Disabilities Act (ADA) requirements and any other federal, state, and/or local ordinances and requirements that may apply.
- ❖ The CSN Fund may approve a **platform lift** if a wheelchair ramp will not meet ADA standards.
- ❖ A signed landlord agreement (Form DCH-2424) must be included if you live in a rental property.
- ❖ Three (3) bids/quotes with installation diagrams are required. The CSN Fund will only pay up to the amount of the lowest bid received or the maximum amount allowed, whichever is lower.

### CSN Fund will NOT cover

- ❖ Personal care items, baby/video monitors, devices, equipment and appliances routinely found in a home
- ❖ Home improvements or repairs
- ❖ Vehicle repairs and routine maintenance, or assistance with the purchase or lease of a vehicle
- ❖ Generators, humidifiers, air purifiers, heating/furnace installation
- ❖ Central air conditioning or ceiling/stair lift in a rental property.

*Note: Requests other than those listed on page 1 may be reviewed by the CSN Fund Advisory Committee.*

### What do I need to submit to request an item?

- A complete CSN Fund Application (Form DCH-1239)
- Complete Financial Assessment Form DCH- 1273 (if your child **IS NOT** enrolled in CSHCS)
- A letter from you explaining the need and reason for the request
- A letter of medical necessity from the child's specialty physician (or assessment from PT/OT for tricycles or adaptive recreational equipment)
- Rifton (or AMTRYKE) order form completed by OT/PT (if applying for Rifton or AMTRYKE)
- Complete Documentation of Assistance form (DCH-2423) form. This is documentation showing that you have contacted at least two (2) other resources (i.e., professional organizations, community service groups/charities, insurance companies) for assistance
- The required bids/quotes must be from different vendors for the item you are requesting. These vendors must be willing to register and bill the State of Michigan
- Signed landlord agreement form (DCH-2424) form (wheelchair ramp or electrical upgrade on a rental property)

*PLEASE NOTE: Requests may not be processed if the application is not completely filled out or the required documentation is not attached.*



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# Application

**1. Check the item you are requesting:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Adaptive Recreational Equipment | <input type="checkbox"/> Electrical Upgrade               | <input type="checkbox"/> Vehicle Accessibility Device   |
| <input type="checkbox"/> Air Conditioner - Portable      | <input type="checkbox"/> Platform Lift (in place of ramp) | <input type="checkbox"/> Weighted Blanket/Vest          |
| <input type="checkbox"/> Air Conditioner - Window Unit   | <input type="checkbox"/> Therapeutic Tricycle/Bicycle     | <input type="checkbox"/> Wheelchair Ramp                |
| <input type="checkbox"/> Central Air Conditioning        | <input type="checkbox"/> Transit Option                   | <input type="checkbox"/> Other (please describe): _____ |
| <input type="checkbox"/> Ceiling Lift or Stair Lift      |   |   |

**2. Please read pages 1-5 of the application guidelines before you complete this application.**

Applicant's (Child) Information		Parent or Guardian Information	
Last Name		Last Name	
First Name		First Name	
CSHCS ID #	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 10-digits	Relationship:	Do you:
Date of Birth	____ / ____ / ____ DD MM YYYY	<input type="checkbox"/> Custodial Parent	<input type="checkbox"/> Rent your home?
		<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Own your home?
		Interpretation or Translation Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address		City	State <b>Michigan</b>
		Zip Code	
Home Phone #	Cell Phone #	Email	Preferred Method of Contact:
		<input type="checkbox"/> Home Phone	
		<input type="checkbox"/> Cell Phone	
		<input type="checkbox"/> Email	
CSHCS Local Health Department (County where you live)		Did your local CSHCS Health Department assist with this application? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**3. If applying for an Air Conditioner, please read page 3 of the application guidelines.**

Room square footage:

**4. Please check any program from which your child currently receives services:**

- |  |   |
|--|---|
| <input type="checkbox"/> Adoption Medical Subsidy*                     | <input type="checkbox"/> Habilitation Support Waiver* |
| <input type="checkbox"/> Children's Waiver (not eligible for CSN Fund) | <input type="checkbox"/> Trust/Insurance Settlement*  |
| <input type="checkbox"/> Community Mental Health*                      |   |

\*You must apply to this agency/program first. If your request is denied, a copy of the denial letter needs to be submitted with this application. The CSN Fund is the payor of last resort.

**5. Preferred Vendor Information (if applicable):**

**Application Checklist: (Read pages 1-5 on the application guideline to ensure your application is complete)**

- Complete application Form DCH-1239
- Complete Financial Assessment Form DCH- 1273 (ONLY if your child is not enrolled in the CSHCS program)
- A letter from you explaining the need and reason for the request
- A letter of medical necessity from the child's specialty physician
- Complete Documentation of Assistance Form DCH-2423
- Bids/quotes required for the item you are requesting (Please read Application guideline pg. 1-5)
- Complete Rifton Order Form DCH-1342 (for Rifton Tricycle Requests only)
- Signed landlord agreement Form DCH-2424 (for a wheelchair ramp or electrical upgrade on a rental property)

**Signature(s):** I certify that the information on this form is true and complete to the best of my knowledge. I understand that this application may be reviewed by the CSN Fund Advisory Committee.

Signature of requester	Date	Signature of parent/guardian	Date
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# Financial Assessment

If you are **NOT** enrolled in Children Special Health Care Services (CSHCS) you must complete this Financial Assessment form and include it with your CSN Fund Application (DCH-1239)

**Applicant's Information**

**Custodial/Non-custodial Parent or Guardian Information**

Last Name	Last Name
First Name	First Name

Does the child live in a foster home or private placement agency?  Yes  No

**Income information**

Enter the total number of claimed exemptions from your most recent federal tax form..... \_\_\_\_\_

Enter the responsible party's income from the most recent **Federal Tax Form** (2019 is Line 8b or 2020 is Line 11 of the Federal 1040) ..... \$ \_\_\_\_\_

**The person signing is the:** (check one)

- Custodial Parent     
  Non-Custodial Parent     
  Legal Guardian     
  Foster Parent of Child  
 Adult Client (between 18 to 21 years old)

**Income Verification**

- ❖ I certify under the penalty of perjury that the information on this form is true, complete, and accurate to the best of my knowledge.
- ❖ I authorize the State of Michigan to verify any information on this form.

Signature of Adult Client or Legally Responsible Party	Date Signed
Print Name Signed Above	



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# Documentation of Assistance

The Children with Special Needs Fund (CSN Fund) requires documentation showing that you have contacted at least two (2) other organizations (e.g., professional, civic, faith-based, or community-based organizations, etc.) for assistance in purchasing the equipment/item you are requesting. Please complete this form and submit it with your application. Be sure to include any letters or e-mails received from these sources.

- 1. Name of organization you contacted:
a. Date of contact:
b. Name of representative you contacted:
c. Phone number of organization:
d. Can they help with funding the request? YES NO
e. If yes, how much will they contribute towards the item/equipment? \$

- 2. Name of organization you contacted:
a. Date of contact:
b. Name of representative you contacted:
c. Phone number of organization:
d. Can they help with funding the request? YES NO
e. If yes, how much can they contribute towards the item/equipment? \$

I certify that the information on these forms is true, complete, and accurate to the best of my knowledge.

Form with fields for Name, Signature of Requester, and Date.



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# Landlord Agreement

This form should be completed by the **landlord/owner** of the rental property where the requestor resides.

<b>1. Name of landowner/landlord:</b>			
<b>2. Address of the landowner/landlord:</b>			
Street Address			Apt. #
City	State	Zip Code	
<b>3. Address of the <u>rental property</u> where modification will be made:</b>			
Street Address			Apt. #
City	State	Zip Code	
<b>4. Name of tenant residing at the rental property above:</b>			

I, the landlord/landowner, give permission to the Children with Special Needs Fund (CSN Fund) to fund a  wheelchair ramp or  electrical upgrade to the rental property at the address listed above.

I certify that the agreement between the landlord and the tenant allows the tenant to make the modification above to the property and if it doesn't, I agree to amend the lease with the tenant accordingly.

Landlord Signature \_\_\_\_\_ Date: \_\_\_\_\_

Tenant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The Children with Special Needs Fund (CSN Fund) is not liable for damages or charges incurred from damages to the property listed above during or after the modification, or restoration of the property to its original condition whether or not the tenant relocates from the property.



# Rifton Tricycle Order Form


Complete this form **ONLY** when Requesting Rifton Tricycles.













**Note:** To be completed by the child's physical/occupational therapist.

**For therapist:**

1. Measure your client to determine the size you need. (See dimension chart for help).
2. Select the appropriate size and color.
3. Select the accessories needed.



User dimensions (inches)	R120 small	R130 medium	R140 large
Inside leg length	17–22	22–28	25–35
 <b>Key user dimension: inside leg length</b> The extended leg should reach from seat to pedal comfortably when both feet and torso are strapped into place.	<b>Important:</b> User's weight must not exceed the maximum working load. Rifton tricycles are not intended for clients with strong reflexes or poorly developed trunk balance and head control. Consult your client's therapist before ordering.		
	Item dimensions (inches)	R120 small	R130 medium
Overall height	37	40	53
Overall length	45	52	65
Overall width	27	27	31
Wheel diameter	13	15	19
Seat center to extended pedal	17–22	22–28	25–35
Seat to top of trunk support	15½–22	15½–22	15½–22
Gear ratio (approximate)	1:1	1:1	1:1
Item weight (lbs.)	47	56	65
Distance between trunk laterals	8–14	8–14	8–14
Max. working load (lbs.)	150	160	200

		R120 small	R130 medium	R140 large		
<b>Required components</b>	<b>Rifton Tricycle</b> frame includes self-leveling pedals with straps, backrest tube with handle and tote box for storage. <b>Specify color:</b> Red, blue, lime or raspberry.	R112 <input type="checkbox"/>	R113 <input type="checkbox"/>	R114 <input type="checkbox"/>		
		RED <input type="checkbox"/> BLU <input type="checkbox"/> RAS <input type="checkbox"/> LIM <input type="checkbox"/>	RED <input type="checkbox"/> BLU <input type="checkbox"/> RAS <input type="checkbox"/> LIM <input type="checkbox"/>	RED <input type="checkbox"/> BLU <input type="checkbox"/> RAS <input type="checkbox"/> LIM <input type="checkbox"/>		
	<b>Seat</b>  CHOOSE	Small <input type="checkbox"/>	R122 <input type="checkbox"/>	R132 <input type="checkbox"/>	N/A	
	Large <input type="checkbox"/>	R128 <input type="checkbox"/>	R138 <input type="checkbox"/>	(included)		
<b>Handlebar</b>  CHOOSE	Conventional <input type="checkbox"/>	R126 <input type="checkbox"/>	R136 <input type="checkbox"/>	R146 <input type="checkbox"/>		
	Loop <input type="checkbox"/>	R129 <input type="checkbox"/>	R139 <input type="checkbox"/>	R149 <input type="checkbox"/>		
<b>Back support</b>  CHOOSE	Trunk support system <input type="checkbox"/>	R147 <input type="checkbox"/>	R147 <input type="checkbox"/>	R147 <input type="checkbox"/>		
	Backrest pad <input type="checkbox"/>	R145 <input type="checkbox"/>	R145 <input type="checkbox"/>	R145 <input type="checkbox"/>		
<b>Optional accessories</b>	<b>Headrest</b> (requires trunk support system)  CHOOSE	Contoured <input type="checkbox"/>	R156 <input type="checkbox"/>	R156 <input type="checkbox"/>	R156 <input type="checkbox"/>	
	Flat <input type="checkbox"/>	R157 <input type="checkbox"/>	R157 <input type="checkbox"/>	R157 <input type="checkbox"/>		
	<b>Handbrake</b> (Must be factory-installed. Cannot be added after trike is manufactured.) 	N/A	R125 <input type="checkbox"/>	(included)		
	<b>Communication tray</b> (Max. working load (lbs) Small: 10 Large: 15)  CHOOSE	Small 8½" x 12½" <input type="checkbox"/>	K225 <input type="checkbox"/>	K225 <input type="checkbox"/>	K225 <input type="checkbox"/>	
	Large 11½" x 13½" <input type="checkbox"/>	N/A	K245 <input type="checkbox"/>	K245 <input type="checkbox"/>		
	<b>Abductor</b> 	R121 <input type="checkbox"/>	R131 <input type="checkbox"/>	R141 <input type="checkbox"/>		
	<b>Front guide bar</b> 	R135 <input type="checkbox"/>	R135 <input type="checkbox"/>	R135 <input type="checkbox"/>		
	<b>Rear steering bar</b> 	R123 <input type="checkbox"/>	R123 <input type="checkbox"/>	R143 <input type="checkbox"/>		
	<b>Front pulley</b> 	R144 <input type="checkbox"/>	R144 <input type="checkbox"/>	R144 <input type="checkbox"/>		
	<b>Additional backrest pad</b> 	R145 <input type="checkbox"/>	R145 <input type="checkbox"/>	R145 <input type="checkbox"/>		
<b>Stationary stand</b> 	R155 <input type="checkbox"/>	R155 <input type="checkbox"/>	R155 <input type="checkbox"/>			
<b>Total</b>	<b>R120</b>	\$ _____	<b>R130</b>	\$ _____	<b>R140</b>	\$ _____

**Name of Therapist Completing Form:**

**Phone:**



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 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, 4<sup>th</sup> Floor  
P.O. Box 30195  
Lansing, MI 48909

517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax),  
[MDHHS-ComplianceOffice@michigan.gov](mailto:MDHHS-ComplianceOffice@michigan.gov)

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

<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 <a href="https://bit.ly/2pBS4YG">https://bit.ly/2pBS4YG</a>, 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 <a href="https://bit.ly/2IKsHMS">https://bit.ly/2IKsHMS</a>.</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: <a href="https://bit.ly/2g9zzpU">https://bit.ly/2g9zzpU</a> or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all of 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: <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a></p>
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MDHHS is an equal opportunity provider.