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 INSTRUCTIOINS:

- Read ALL instructions FIRST.
- Complete **Section 1**.
- Complete **Section 2** only if you want someone to represent you at the hearing.
- **Do NOT** complete Section 4.
- Please use PEN and PRINT.
- If you have any questions, please call toll free: **1 (877) 833 - 0870**.
- Make a copy for your records 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:

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE 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, or hearing, you are invited to make your needs known to the Department of Community Health.

If you do not understand this, call the Department of Community Health at (877) 833-0807. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.	**1 (877) 833 - 0807**
Completion:	Is Voluntary

Revised: 02/13/2008

See the Request Form

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STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE 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.)			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.***

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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?

☐ **NO** ☐ **YES** (If YES, have the individual complete section 3)

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		

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.)			Agency Telephone Number
City	State	Zip Code	State Program or Service being provided to this appellant

Revised: 02/13/2008