# 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:

**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) 833-0870.<br>Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.<br>إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية ميتشيجن. | **1 (877) 833 - 0870** |
| **Completion:** | Is Voluntary |

**DCH-0092 (SOAHR) INSTRUCTION SHEET (Rev. 3-06)**

***See the Request Form Underneath***

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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<br>( ) | 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.***

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

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 section 3)

## SECTION 3 – Authorized Hearing Representative Information:

| Name of Representative | | | Representative Telephone Number<br>( ) | |
|---|---|---|---|---|
| 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<br>( ) |
| City | State | ZIP Code | State Program or Service being provided to this appellant |