REQUEST FOR AN ADMINISTRATIVE 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 30195
LANSING MI 48909 (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 – Authorized Hearing Representative Information:
Read the information near the top of the Instruction Sheet FIRST

Has Someone Agreed to Represent you at a Hearing?

NO **YES** (If Yes, complete the information below)

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

SECTION 3 – To be completed by the AGENCY distributing this form to the appellant:

Name of Agency Oakland County Community Mental Health Authority			AGENCY Contact Person Name Michael Daley, Hearing Coordinator
AGENCY Address (No. & Street, Apt. No., etc.) 1200 N. Telegraph Rd., Building 38-East			AGENCY Telephone Number (248) 975-9642
City Pontiac	State MI	ZIP Code 48341	State Program or Service being provided to this appellant: Community Mental Health Services