Case Name:
Case Number:
Date:
MDHHS Office:
Specialist / ID: /
Phone:
Fax:
Individual ID:

STATE OF MICHIGAN
Department of Health and Human Services

If you do not understand this, call an MDHHS office in your area. MDHHS employees are prohibited by law from providing legal advice.
Si ústed no entiende esto, llame a una oficina de MDHHS en su área. La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فأتصل بمكتب MDHHS الموجود في منطقتك. يحرّم القانون على موظفي MDHHS إعطاء النصيحة القانونية.

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.

"USDA is an equal opportunity provider and employer."

AUTHORITY: MCL 400.9, MSA 16,409
RESPONSE: Voluntary.
PENALTY: None

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

REQUEST FOR HEARING

INSTRUCTIONS: Complete items 1 through 14 on following page. Please type or print. **DELIVER OR MAIL completed form to your local MDHHS office, Attn: Hearing Coordinator.** A date-stamped copy will be returned to you by the local office.

Date Received in MDHHS	Program(s) in Dispute

If you do not agree with any decision made by MDHHS to deny, reduce or terminate benefits, you have the right to request a hearing. In most cases, if you receive a notice reducing or canceling your benefits and you request a hearing no more than 11 days after the date the action will take place, your benefits will continue until the hearing is decided. Although, if the MDHHS decision to deny, reduce or terminate your benefits is upheld, you will be required to repay any additional benefits received because the action was postponed.

Someone else may represent you at the hearing, such as a friend, relative, or lawyer. Hearings will be conducted by telephone unless an in-person hearing is requested.

To Ask for a Hearing:
A request for an administrative hearing must be made in writing and signed by you or someone authorized to act on your behalf. For convenience, MDHHS provides **a hearing request form that you should *bring* or *mail* to your MDHHS office** (***no*** *faxes or photocopies)*. For FAP (food assistance) only, you can request a hearing verbally, in person or by telephone. Except for FAP, the hearing request must be signed by you or by your parent, attorney, court appointed guardian or conservator, or by someone else you formally designate as your Authorized Hearing Representative. For Medicaid only, a spouse may sign a written request for a hearing without first being designated an Authorized Hearing Representative.

Appointment of an Authorized Hearing Representative:
The appointment of an authorized hearing representative must be made in writing and signed by you before that person can make a hearing request, or take any other action on your behalf. The Hearing request will be denied if it is signed by a person not authorized by law, court order, or a signed statement from you.

Your Hearing Request will be Denied if:
- We receive your request more than 90 days after we mail the notice to deny, terminate, or reduce your benefits.
- The person who signed the hearing request cannot show a court order or a signed statement from you, and is not your lawyer, spouse or parent.

Persons with Disabilities or Needing Special Arrangements:
Special arrangements at the hearing can be made to accommodate a physical disability or other barrier to participation that you or someone participating with you needs. If an interpreter is required, please indicate the language skills needed. Tell your MDHHS specialist if you need help.

Case Name	Case Number	Specialist

1. Please check only the box(es) of the benefit program(s) you are asking to have heard before an administrative law judge and the action taken which you are challenging.

☐ FIP (Cash)	☐ Denied	☐ Closed	☐ Amount	☐ FAP (Food)	☐ Denied	☐ Closed	☐ Amount
☐ MA (Medical)	☐ Denied	☐ Closed	☐ Amount	☐ SER (Emergency Relief)	☐ Denied	☐ Closed	☐ Amount
☐ CDC (Child Care)	☐ Denied	☐ Closed	☐ Amount	☐ SDA (Cash)	☐ Denied	☐ Closed	☐ Amount
☐ Other _____	☐ Denied	☐ Closed	☐ Amount				

2. I request a hearing before an Administrative Law Judge regarding the decision of the _____ County
Name of County

Michigan Department of Health and Human Services. I believe the department's decision is wrong because:
EXPLANATION:

3. If necessary for participation at the hearing and upon request, arrangements can be made to accommodate a physical disability. If an interpreter is required, please indicate what language.

Please identify the disability or language barrier, and explain what arrangements are required:

If at the hearing, you are denied special help or an exception you need because of a disability and you think the denial was wrong, you may file a complaint of discrimination using the DHS-866 form. The DHS-866 provides the address for filing a complaint with the MDHHS Office of Human Resources.

By signing this form, I acknowledge that I have read and understand the following rights and obligations: Because I am asking for a hearing, the MDHHS may postpone the proposed action until I have had a hearing and a decision is issued by an Administrative Law Examiner. If MDHHS' proposed action is upheld, I will be required to repay any additional benefits that I received because the proposed action was postponed. If I withdraw this hearing request, or if I do not go to the hearing when it is scheduled, I will be required to repay any additional benefits that I received because the proposed action was postponed.

I ☐ DO ☐ DO NOT want to continue receiving the amount of food assistance I now receive until after my hearing.

4. **Signature of Person Requesting Hearing** (AH must receive an original signature. If this form is signed by an authorized hearing representative, documentation of authorization must be attached.)	5. Telephone Number	6. Date
	7. Case Number:	
8. Street Address or Route Number	9. City, State and Zip Code	

THIS SECTION TO BE COMPLETED ONLY IF SOMEONE HAS AGREED TO REPRESENT YOU AT THE HEARING.

10. Name of Authorized Hearing Representative	11. Telephone Number	12. Title
13. Street Address or Route Number	14. City, State, and Zip Code	
El Michigan Department of Health and Human Services (MDHHS) no discrimina contra ningún individuo o grupo a causa de su raza, religión, edad, origen nacional, color de piel, estatura, peso, estado matrimonial, información genética, sexo, orientación sexual, identidad de sexo o expresión, creencias políticas o incapacidad.	Michigan Department of Health and Human Services لن تمييز ادارة الخدمات الصحية و الانسانية لولاية ميشيغان (MDHHS) ضد أي فرد أو مجموعة بسبب العرق، أو الديانة، أو العمر، أو الأصل الوطني، أو اللون، أو الطول، أو الوزن، أو الحالة الزوجية، أو المعلومات الجينية، أو الجنس، أو التوجه الجنسي ،أوالهوية الجنسية أو التعبير، أو المعتقدات السياسية، أو الإعاقة.	