REQUEST for HEARING for MEDICAID ENROLLEES or WAIVER APPLICANTS

Instructions

To appeal an action related to cash assistance, food assistance, or other assistance programs, you must use the Request for Hearing form (DHS-18) available online at www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Forms and Applications >> Other.

Medicaid enrollees (not Medicaid applicants) **or waiver applicants may use this form to request a hearing.** You may also submit your signed hearing request in writing on any paper. This form is also available on-line at www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Medicaid Fair Hearings or www.michigan.gov/LARA >> MI Administrative Hearing System >> Benefit Services.

A hearing is an impartial review of a decision made by the Michigan Department of Health and Human Services, or one of its contract agencies, that a client believes is wrong.

GENERAL INSTRUCTIONS:

- Read ALL instructions before completing the attached form.
- Complete **Section 1** using the name of the client (even if the client has a guardian or is a minor).
- Complete **Section 2** only if you want someone to represent you at the hearing.
- You do not need to complete Section 4; the agency who took the action you are appealing should.
- Attach a copy of the notice or letter from the agency telling you about the change you want to appeal.
- Please make a copy for your records.
- If you have any questions, please call toll free: **1 (877) 833 - 0870**.
- After you complete this form, mail or fax to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 30763
LANSING MI 48909
Fax (517) 763-0146

- 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 must be included with this request or it cannot be processed.**

- 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.
- If you need help with reading, writing, or hearing, you are invited to make your needs known to the Michigan Department of Health and Human Services.

If you do not understand this, call the Michigan Department of Community Health at (877) 833-0870. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية مينتشيجن.	**1 (877) 833 - 0870**

Completion:	Is Voluntary

See the Request Form Underneath

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SECTION 1 – To be completed by PERSON REQUESTING A HEARING:

Client Name			Your Telephone Number ( )	Client Social Security Number
Client's Address (No. & Street, Apt. No.)			Client or Legal Guardian Signature	Date Signed
City	State	ZIP Code		
What agency took the action or made the decision that you are appealing? (KCMHSAS) *Make sure to attach a copy of the letter from the agency telling you about their decision.*				Client MDHHS 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 and sign 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		

☐ I want to request an In-Person Hearing with the Judge at my agency.

☐ I want to request an *Expedited Hearing* to be scheduled as soon as possible.

SECTION 4 – To be completed by the AGENCY involved in the action being disputed by the client

Name of AGENCY			AGENCY Contact Person Name
Southwest Michigan Behavioral Health <KCMHSAS>			Ashley Esterline
AGENCY Address (No. & Street, Apt. No.)			AGENCY Telephone Number
5250 Lovers Lane, Suite 200			**(800) 890-3712**
City	State	ZIP Code	State Program or Service being provided to this client
Portage	MI	49002	

☐ Individual is enrolled in the MI Health Link program.

THIS FORM IS ALSO AVAILABLE ONLINE AT: www.michigan.gov/LARA >> MI Administrative Hearing System >> Benefit Services