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 30763
LANSING MI 48909 **1 (877) 833-0870**

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			AGENCY Contact Person Name
AGENCY address (No. & Street, Apt., No., etc.)			AGENCY Telephone Number
City	State	ZIP Code	State Program or Service being provided to this appellant