## REQUEST FOR HEARING FOR MEDICAID ENROLLEES, PACE ENROLLEES OR WAIVER APPLICANTS

Michigan Office of Administrative Hearings and Rules Michigan Department of Health and Human Services PO Box 30763, Lansing, MI 48909

Client Telephone No.

Client Social Security No.

Telephone Number: 800-648-3397 Fax: 517-763-0146

### SECTION 1: TO BE COMPLETED BY THE PERSON REQUESTING A HEARING

Client Address (No. and Street, Apt. No.)				Medicaid ID No.		
City	State	Zip Code		Client or Legal Guardian S	Signature	Date
			, , ,		Client MDHHS Case No.	
I WANT TO REQUEST A additional sheets if need		<b>G:</b> The followi	ing a	re my reasons for requesti	ng a heari	ng. <b>Use</b>
Do you have a physical d participate in a hearing?  ☐ No ☐ Yes (If yes, ple	•		ion re	equiring special arrangeme	nts for you	u to attend or
Will you need an interpret  ☐ No ☐ Yes (If yes, la		reeded:)				
SECTION 2: HAVE YOU	CHOSEN	SOMEONE	TOR	EPRESENT YOU AT THE	HEARIN	G?
Has someone agreed to r ☐ No ☐ Yes (If Yes, has	•	•	•	g? olete and sign Section 3.)		
SECTION 3: AUTHORIZE	DHEAR	ING REPRES	SENT	TATIVE INFORMATION		
Name of Representative (please print)		Repr	resentative Telephone No.	Relationship to Enrollee		
Address (No. and Street, Apt. No.)		City		State	Zip Code	
Representative Signature				Date Signed		
SECTION 4: AGENCY IN	VOLVED	IN THE ACT	ION	BEING DISPUTED BY TH	E CLIENT	Γ
Name of Agency			Agency Contact Person Name			
Agency Address (No. and Street, Apt. No.)				Agency Telephone Number		
City	State	Zip Code		State Program or Service b	peina prov	rided to this client

Client Name

## REQUEST FOR HEARING FOR MEDICAID ENROLLEES, PACE ENROLLEES OR WAIVER APPLICANTS INSTRUCTIONS

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.

This form is to ask for a hearing if you are a Medicaid enrollee, or a PACE enrollee, or a Medicaid waiver applicant when the action has been taken by MDHHS or one of its contract agencies. You can also send in your signed hearing request in writing on any paper. This form is also available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Office of Administrative Hearings and Rules for the Department of Health and Human Services or www.michigan.gov/LARA >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings.

#### Do not use this form to appeal an action

- Taken by a Medicaid, Healthy Michigan Plan or MI Health Link health plan, Community Mental Health Services Program / Prepaid Inpatient Hospital Plan (CMHSP/PIHP), Healthy Kids Dental health plan, or MI Choice Waiver Agency. You must go through their internal appeals process first before you ask for a MDHHS-5617-MOAHR, Request for State Fair Hearing form. This form is also available online at the links above.
- Related to program eligibility, cash assistance, food assistance, or other assistance programs. Use
  the DHS-18, Request for Hearing form available online at www.michigan.gov/mdhhs >> Doing
  Business with MDHHS >> Forms and Applications >> Other, or go to
  www.michigan.gov/documents/FIA-Pub18\_14356\_7.pdf to download the form.

#### **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 Sections 2 & 3 only if the client wants someone to represent them at the hearing.
- Complete Section 4 if the agency who took the action you are appealing did not fill this out.
- Attach a copy of the notice or letter from the Agency that told the client about the change that is being appealed.
- Please make a copy for your records.
- Questions can be answered by calling toll free: 800-648-3397.
- After the form is completed, mail or fax page 1 to:

# MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES PO BOX 30763 LANSING MI 48909 Fax 517-763-0146

- The client may choose to have another person represent them at a hearing.
  - This person can be anyone the client chooses but must be at least 18 years of age.
  - The client must give this person written permission to represent them.
  - The client may give written permission by checking yes in Section 2 and having the person who is representing them complete Section 3. The client must still complete and sign Section 1.
  - The client's guardian or conservator may represent them. A copy of the court order naming the guardian or conservator must be included with this request.

Completion: Is Volun	าtarv	١.
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Michigan Department of Health and Human Services (MDHHS)
Please note if needed, free language assistance services are available.
Call 877-833-0870 (TTY users call TY: 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-833-0870 (TTY 711).
Arabic	ملحوظة: إذا كنت تتحث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم -833-877
	0870 (رقم هاتف الصم والبكم:-711 TTY).
Chinese	注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 877-833-
	0870 (TTY 711)
Syriac (Assyrian)	رفیدی کے برمور کے بوحرحبوں لیعبی بحدیوں کے بہوں ۔ دفحلبوں سلخوا کے بوندی کے بادور کے بریونوں کے بریونوں کے بری
	حلقت، مخترت، بلا. عذف بـ خل جينت، (TTY 711) 877-833-0870
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành
Albanian	cho bạn. Gọi số 877-833-0870 (TTY 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 877-833-0870 (TTY 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수
	있습니다. 877-833-0870 (TTY 711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা
	সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১–877-833-0870 (TTY 711)
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy
	językowej. Zadzwoń pod numer 877-833-0870 (TTY 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 877-833-0870 (TTY 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di
lanana.	assistenza linguistica gratuiti. Chiamare il numero 877-833-0870 (TTY 711).
Japanese	注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。
	877-833-0870 (TTY 711) まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны
	бесплатные услуги перевода. Звоните 877-833-0870 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći
	dostupne su vam besplatno. Nazovite 877-833-0870 (TTY Telefon za osobe sa
Togolog	oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga
	serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877-833-0870 (TTY 711).

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. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - o Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - o Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator Compliance Office, 4<sup>th</sup> Floor P.O. Box 30195 Lansing, MI 48909

517-284-1018 (Main), TTY 711, 517-335-6146 (Fax)

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://bit.ly/2IKsHMS.

If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by:

Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form.

To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410

Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.