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| **REQUEST FOR STATE FAIR HEARING** | | | | | | | | | | | | |
| Michigan Department of Health and Human Services | | | | | | | | | | | | |
| Michigan Administrative Hearing System | | | | | | | | | | | | |
| PO Box 30763 | | | | | | | | | | | | |
| Lansing, MI 48909 | | | | | | | | | | | | |
| Telephone Number: 800-648-3397 | | | | | | Fax: 517-763-0146 | | | | | | |
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| This form is for enrollees in a Managed Care Health Plan, MI Health Link\* Plan, Community Mental Health Services Program (CMHSP)/Prepaid Inpatient Health Plan (PIHP), or MI Choice Waiver Program | | | | | | | | | | | | |
| **SECTION 1 – To be completed by the PERSON REQUESTING A STATE FAIR HEARING** | | | | | | | | | | | | |
| Enrollee Name | | | | | Enrollee Telephone Number | | | | Enrollee Social Security Number | | | |
|  | | | | |  | | | |  | | | |
| Address (No.& Street, Apt. No.) | | | | | City | | | | | State | Zip Code | |
|  | | | | |  | | | | |  |  | |
| Enrollee or Legal Guardian Signature | | | | | Enrollee Medicaid ID Number | | | | | | Date Signed | |
|  | | | | |  | | | | | |  | |
| Managed Care Health Plan MI Health Link (\*for Medicaid benefits only) CMHSP/PIHP  MI Choice Waiver | | | | | | | | | | | | |
| Name of Health Plan, CMHSP/PIHP or Waiver Agency that took the action: | | | | | | | |  | | | |  |
|  | | | | | | | |  | | | |  |
| Date of Notice of Appeal Decision (please include a copy of the notice): | | | | | | |  | | | | |  |
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| As of today’s date, I have not received a Notice of Appeal Decision. I sent in an Internal Appeal on: | | | | | | | | | |  | |  |
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| **I am asking for a State Fair Hearing because:** Use additional paper if needed. | | | | | | | | | | | | |
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| Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing? | | | | | | | | | | | | |
| **No** | | | | | | | | | | | | |
| Yes (If yes, please explain 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 representative complete and sign Section 3.) | | | | | | | | | | | | |
| **SECTION 3 – Authorized Hearing Representative Information** | | | | | | | | | | | | |
| Name of Representative (Please Print) | | | | | Representative Telephone Number | | | | Relationship to Enrollee | | | |
|  | | | | |  | | | |  | | | |
| Address (No.& Street, Apt. No.) | | | | | City | | | | | State | Zip Code | |
|  | | | | |  | | | | |  |  | |
| Representative Signature | | | | | Date Signed | | | | | | | |
|  | | | | |  | | | | | | | |
| **SECTION 4 – To be completed by the AGENCY involved in the action being disputed by the enrollee** | | | | | | | | | | | | |
| Name of AGENCY | | | | | AGENCY Contact Person Name | | | | | | | |
| The Right Door for Hope, Recovery and Wellnes | | | | | Susan Richards, LMSW | | | | | | | |
| AGENCY Address (No.& Street, Apt. No.) | | | | | AGENCY Telephone Number | | | | | | | |
| 375 Apple Tree Drive | | | | | 888 527 1790 | | | | | | | |
| City | | State | | ZIP Code | State Program or Service being provided to Enrollee | | | | | | | |
| Ionia | | MI | | 48846 | CMHSP | | | | | | | |
|  | | | | | | | | | | | | |
| This form is also available online at: <http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html> or [www.michigan.gov/LARA](http://www.michigan.gov/LARA) >> MI Administrative Hearing System >> Benefit Services. | | | | | | | | | | | | |

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| **REQUEST FOR STATE FAIR HEARING** | |
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| This form is for enrollees in a Managed Care Health Plan, MI Health Link Plan (\*for Medicaid benefits only), Community Mental Health Services Program (CMHSP)/Prepaid Inpatient Health Plan (PIHP), or MI Choice Waiver Program | |
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| **INSTRUCTIONS** | |
| A State Fair 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 an enrollee believes is wrong. | |
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| **If you are enrolled in a Managed Care Health Plan, MI Health Link, CMHSP/PIHP, or MI Choice Waiver program you MUST finish their internal appeal process before you can ask for a State Fair Hearing. If you do not receive a Notice of Appeal Decision within the mandated timeframe, you may also ask for a State Fair Hearing.** You may also send in your signed hearing request in writing on any paper. This form is also available online at: [www.michigan.gov/mdhhs](http://www.michigan.gov/mdhhs) >> Assistance Programs >> Medicaid >> Medicaid Fair Hearings or [www.michigan.gov/LARA](http://www.michigan.gov/LARA) >> MI Administrative Hearing System >> Benefit Services.  **If you asked for your benefit(s) to continue during the internal appeal process and you want them to continue during the State Fair Hearing process, you must ask for the State Fair Hearing and Michigan Administrative Hearing System (MAHS) must receive your request within 12 calendar days of the date on the Notice of Appeal Decision.** | |
| **General Instructions:**   * Read ALL instructions before completing the attached form. * This form should not be used for a request for a hearing related to: * Public Assistance (Medicaid eligibility, cash assistance, food assistance, or other assistance programs). For these hearing types, you must use form DHS-18, Request for Hearing available online at <http://www.michigan.gov/documents/FIA-Pub18_14356_7.pdf> . * A decision that does not involve a managed care entity on a Medicaid service or your application for a MI Choice Waiver program. For these hearings types you must use form DCH-0092, Request for Hearing for Medicaid Enrollees or Waiver Applicants available online at: [www.michigan.gov](http://www.michigan.gov) >> Assistance Programs >> Medicaid >> Medicaid Fair Hearings or <http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html>. * Please attach a copy of the Notice of Appeal Decision that you received from your managed care organization. * Complete **Section 1** using the name of the enrollee (even if the enrollee has a guardian or is a minor). * Complete **Section 2 and 3** only if you want someone to represent you at the hearing. * Complete **Section 4** if the agency who took the action you are appealing did not fill this out. * Please make a copy of this completed form for your records. * If you have any questions, call: **517-373-0722 or** toll freeat **800-648-3397**. * After you complete this form, mail or fax (**no email**) to:   **MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**  **MICHIGAN ADMINISTRATIVE HEARING SYSTEM**  **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 and signed 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.** | |
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| 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 do not understand this, call the Michigan Department of Health and Human Services at 877-833-0870.  Si no entiende esta información comuníquese al Michigan Department of Health and Human Services al 877-833-0870. | **877-833-0870** |
| **Completion:** Is Voluntary | |