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 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.

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 **Sections 2 & 3** only if the client wants someone to represent them at the hearing.
- Do NOT complete Section 4.
- 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: **1 (877) 833 - 0870**.
- After the form is completed, mail or fax to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 30763
LANSING MI 48909
Fax (517) 373-4147

- The client may choose to have another person represent them at a hearing.
  - → This person can be anyone the client chooses but he/she 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 must be included with this request.**

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

</td></tr>
<tr><td>If you do not understand this, call the Michigan Department of Community Health at (877) 833-0870.
Si no entiende esta información, comuníquese al Michigan Department of Health and Human Servicies al (877) 833-0870.
إذا كنت لا تفهم هذا، فعليك الاتصال بـ Michigan Department of Health and Human Services (وزارة الصحة والخدمات الإنسانية) على رقم الهاتف 0870-833 (877).</td><td>1 (877) 833 - 0870</td></tr>
<tr><td>Completion:</td><td>Is Voluntary</td></tr>
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See the Request Form Underneath

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

Client Name			Client 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 the client is appealing? *Make sure to attach a copy of the letter from the agency that told the client 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.***

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Does the client have physical or other conditions requiring special arrangements to attend or participate in a hearing?

☐ **NO**

☐ **YES** (Please Explain in **Here**):

SECTION 2 – Has the client chosen someone to represent them at the hearing?

Has someone agreed to represent the client at a hearing?

☐ **NO** ☐ **YES** (If YES, have the representative complete and sign section 3)

SECTION 3 – Authorized Hearing Representative Information

Name of Representative			Representative Telephone Number ( )	
Representative Address (No. & Street, Apt. No.)			Representative Signature	Date Signed
City	State	ZIP Code		

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

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

THIS FORM IS ALSO AVAILABLE ONLINE AT: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Medicaid Fair Hearings