REQUEST FOR REVIEW
BY LOCAL DISPUTE RESOLUTION PROCESS

Form to be completed by, or in behalf of the Consumer.

Name (Consumer)	Date of Request
Address City: State: Zip:	Daytime Phone:
Name of Your Guardian or Authorized Representative: Address	Location and name of Service Provider where services are in question: **NSO/OLDER ADULT SERVICES** **882 Oakman Blvd, Suite D** **DETROIT, MICHIGAN 48238** **(313) 961-7990**

Name and Address of Service Provider that made the decision being appealed:

NSO/Older Adult Services; 882 Oakman Blvd, Suite D; Detroit, Michigan 48238; (313) 961-7990

Date of Decision You are Appealing:

Describe the service being denied, suspended, reduced or terminated to you:

Describe the way this action affects you.

Do you want Mediation of your dispute? (circle one): Yes No

COMPLETE AND MAIL TO:

Office of Recipient Rights: **Detroit-Wayne Mental Health Authority**
NAME OF SERVICE PROVIDER / HOSPITAL

707 W. Milwaukee Ave; Detroit, Michigan 48202; 1-344.9099; 1800-630-1044 (TDD)
ADDRESS