



MANUAL TITLE	BENEFICIARY ELIGIBILITY	SECTION 2	CHAPTER 1	PAGE 15
CHAPTER SUBJECT	BENEFICIARY HEARINGS	DATE 06-15-98 BE 98-01		

ATTACHMENT A

HEARING RIGHTS LANGUAGE

The following is DCH Standard language that informs a beneficiary of their right to a hearing. It must be included on the written notice that is sent whenever action is taken by DCH or one of its contracted agencies to deny eligibility, or when action is taken to reduce or terminate medical services:

PROCEDURES FOR REQUESTING A HEARING

If you disagree with this action, you may request a hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person. You may choose anyone to represent you. If you want someone else to request a hearing for you or represent you at the hearing, that person must first have your written authorization to do so unless that person is your attorney or your spouse. The Department of Community Health Administrative Hearings must have proof that you authorized the person to request the hearing or a copy of a court order naming the person as your guardian or conservator. Otherwise your hearing request will be denied.

If you are currently receiving medical benefits and your hearing request is received before (12 days), this action will not be taken at this time. However, you might be required to repay any contested medical benefits which you receive as a result of your request for a hearing if the Department's proposed action is upheld in the hearing decision; if your hearing request is withdrawn; or you or your authorized hearings representative do not attend the hearing.

To request a hearing, complete the enclosed Hearing Request, and return it in the enclosed envelope, or mail to:

Department of Community Health
Administrative Tribunal
P. O. Box 30195
Lansing MI 48909-7695

If you want to know more about how a fair hearing works or to find out if free legal help is available, call 1-800- 642-3195.



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HEARING REQUEST

Michigan Department of Community Health

To be Completed by DCH Staff Only

Beneficiary Name		Date Sent				
Case Number			Recipient ID No.			
County Name	Co.	Dist.	Sec.	Unit	Wkr.	

The purpose of this form is for a beneficiary to request an administrative hearing.

BENEFICIARY INSTRUCTIONS:

- Answer questions in SECTIONS 1 & 2 ONLY
- Please use a PEN and PRINT FIRMLY.
- Remove the BOTTOM copy for your records.
- If you have any questions, please call the Medicaid Helpline at: 1 (800) 642 - 3195.
- After you complete this form, mail it in the enclosed postage paid envelope to:
**ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30195
LANSING MI 48909-7695**

SECTION 1 - To be completed by BENEFICIARY:

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):

Has Someone Agreed to Represent you at a Hearing?
 NO YES (Please Explain in Section 2 Below):

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

SECTION 2 - Hearing Representative Information:

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

<p>Authority: 42 CFR 431.200 - 431.250 Completion: Is Voluntary, but if NOT completed, a hearing will not take place</p>	<p>The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Department of Community Health.</p>
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If you do not understand this call the Department of Community Health.
 Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. **1 (800) 642 - 3195**

DCH-0092 (W) (4/98) DISTRIBUTION: WHITE - Administrative Tribunal, YELLOW - DCH / MSA, PINK - Beneficiary Copy



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<p align="center">AGENCY REVIEW OF HEARING REQUEST</p> <p align="center">Michigan Department of Community Health Administrative Tribunal</p>		<i>To be Completed by DCH Staff Only</i>						
		Beneficiary Name		Date Sent				
		Case Number		Recipient ID No.				
		County Name		Co.	Dist.	Secl.	Unit	Wkr.
Agency Type: <i>(check ONE and enter specific Name to the Right)</i> <input type="checkbox"/> DCH - MSA <input type="checkbox"/> DCH - OTHER <input type="checkbox"/> CONTRACT AGENCY:		Name of DCH Office or Contracting Agency						
Hearing Type: <i>(check ALL that apply)</i> <input type="checkbox"/> Denial of Prior Authorization <input type="checkbox"/> Denial of Medicaid Payment <input type="checkbox"/> Denial / Closure of TMA Plus <input type="checkbox"/> Denial of Medical Exception <input type="checkbox"/> Denial of Home Help Services <input type="checkbox"/> Denial of DCH Waiver Program		<input type="checkbox"/> Denial of CSHCS Medical Eligibility <input type="checkbox"/> Denial of Children's Waiver Services <input type="checkbox"/> Category of Care <input type="checkbox"/> Denial of Waiver Services <input type="checkbox"/> Reduction of Services <input type="checkbox"/> Managed Care Issues			<input type="checkbox"/> Level of Care (LTC or HCBS Waiver) <input type="checkbox"/> Recipient Monitoring Restriction <input type="checkbox"/> Reduction of Services <input type="checkbox"/> Other (explain):			
Issues in Dispute:								
Pre-Hearing Resolution (If Applicable)								
DCH Staff or Contracting Agency Signature					Telephone Number			
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HEARING SUMMARY		Case Name			
Michigan Department of Community Health Administrative Tribunal		Case Number	Co.	Dist.	Sect.
		Unit	Wkr.		
1. Date Hearing Requested	2. Effective Date of Action	3. Date Client Notified of Department Action		4. Deleted Pending Hearing? <input type="checkbox"/> NO <input type="checkbox"/> YES	
5. Date Offered Case Conference	6. Was This Date Accepted? <input type="checkbox"/> NO <input type="checkbox"/> YES	7. Date of Administrative Review			
11. Explanation of Action(s) Taken:					
12. Facts and Fact Sources used in taking this action(s):					
13. Law(s), Regulation(s) or Policy Manual Item(s) used in taking action:					
14. Prepared By: (Signature)			15. Date		
If you do not understand this call the Department of Community Health. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة للمصلحة التابعة لولاية ميشيغان.				1 (800) 642 - 3195	
The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Family Independence Agency office in your county.					
DCH-0367 (W) (4-98)					



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HEARING REQUEST WITHDRAWAL		<i>To be Completed by DCH Staff Only</i>					
Michigan Department of Community Health Administrative Tribunal		Beneficiary Name			Date Sent		
		Case Number			Recipient ID No.		
		County Name		Co.	Dist.	Secl.	Unit
<p>The purpose of this form is for a beneficiary to withdraw his / her request for an administrative hearing.</p> <p>BENEFICIARY INSTRUCTIONS:</p> <ul style="list-style-type: none"> • Answer questions in SECTION 1 ONLY • Please use a PEN and PRINT FIRMLY. • Remove the BOTTOM copy for your records. • If you have any questions, please call the Medicaid Helpline at: 1 (800) 642 - 3195. <p>• After you complete this form, mail it in the enclosed postage paid envelope to: ADMINISTRATIVE TRIBUNAL MICHIGAN DEPARTMENT OF COMMUNITY HEALTH PO BOX 30195 LANSING MI 48909-7695</p>							
<p>SECTION I - To be completed by BENEFICIARY:</p> <p>I DO NOT WANT A HEARING: Please cancel my request for a hearing for the following reason. <i>Check the appropriate box below:</i></p> <p><input type="checkbox"/> I now understand that the action taken by the Department of Community Health was correct.</p> <p><input type="checkbox"/> The Department of Community Health has changed its action.</p> <p><input type="checkbox"/> OTHER - (please explain):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>							
Your Name				Your Telephone Number			
Your Address (No. & Street, Apt. No., etc.)				Your Signature		Date Signed	
City	State	ZIP Code					
The area below this line is to be completed by DCH Staff Only:							
Agency Type: (check ONE and enter specific Name to the Right)				Name of DCH Office or Contracting Agency			
<input type="checkbox"/> DCH - MSA <input type="checkbox"/> DCH - OTHER <input type="checkbox"/> CONTRACT AGENCY:				▶			
Hearing Type: (check ALL that apply)							
<input type="checkbox"/> Denial of Prior Authorization		<input type="checkbox"/> Denial of CSHCS Medical Eligibility		<input type="checkbox"/> Level of Care (LTC or HCBS Waiver)			
<input type="checkbox"/> Denial of Medicaid Payment		<input type="checkbox"/> Denial of Children's Waiver Services		<input type="checkbox"/> Recipient Monitoring Restriction			
<input type="checkbox"/> Denial / Closure of TMA Plus		<input type="checkbox"/> Category of Care		<input type="checkbox"/> Reduction of Services			
<input type="checkbox"/> Denial of Medical Exception		<input type="checkbox"/> Denial of Waiver Services		<input type="checkbox"/> Other (explain):			
<input type="checkbox"/> Denial of Home Help Services		<input type="checkbox"/> Reduction of Services					
<input type="checkbox"/> Denial of DCH Waiver Program		<input type="checkbox"/> Managed Care Issues					
Issues in Dispute:							
Pre-Hearing Resolution (if Applicable)							
DCH Staff Signature				Staff Telephone Number			
				()			
Authority: 42 CFR 431.200 - 431.250 Completion: Is Voluntary, but if NOT completed, a hearing will not take place		The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Department of Community Health.					
If you do not understand this call the Department of Community Health. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.						1 (800) 642 - 3195	
DCH-0093 (W) (4/98)		DISTRIBUTION: WHITE - Administrative Tribunal, YELLOW - DCH / MSA, PINK - Beneficiary Copy					



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ORDER CERTIFICATION Administrative Hearing or Departmental Review Michigan Department of Community Health	<i>To be Completed by DCH Staff Only</i>					
	Beneficiary Name			Date Sent		
	Case Number		Recipient ID No.			
County Name		Co.	Dist.	Sec.	Unit	Wkr.

INSTRUCTIONS:

- Complete the actions **within 10 Days** of the Decision and Order's mailing date.

CERTIFICATION

I certify that the actions contained in the decision and order **were** completed by _____ on _____
Name Date

_____ **has not been able to**
Name
 comply with the decision and order **within 10 days** for the following reasons:

The expected Action Date is: _____
Date

I certify that the actions contained in the decision and order **were** completed **after 10 days** by: _____ on _____
Name Date

_____ **will never be able to**
Name
 comply with the decision and order for the following reasons:

DCH Staff Signature	Date	Phone Number
Supervisor Signature	Date	

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

DCH-0107 (4/98)

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