St. Clair County Community Mental Health Authority

# Ability to Pay Administrative Hearing Request

Individual: _____ Case #: _____

Guarantor/Responsible Party (if applicable):_____

Address: _____ Telephone #: _____

_____

Fee Determination Effective Date: _____

I am requesting an Administrative Hearing for a redetermination of my Financial Liability for Services received in accordance with Department of Community Health Rules and St. Clair County Community Mental Health Authority Fee Policy.

I understand that this form must be filed within 30 days of the date of the initial, annual or new rate determination with:

St. Clair County Community Mental Health Authority
3111 Electric Ave
Port Huron, Michigan 48060-5416
Attn: Hearing Officer

I understand failure to file this form within 30 days of the date of the initial, annual or new rate determination will result in the financial liability previously assessed to be binding.

_____ _____

Individual/Guarantor (Responsible Party) Signature Date