

St. Clair County Community Mental Health
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 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
Attn: Hearing Officer
3111 Electric Avenue
Port Huron, Michigan 48060

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