Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: August 12, 2025
Docket No.: 25-019020
Case No.: [redacted]
Petitioner: [redacted]

[redacted]

This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

Date Mailed: August 12, 2025
Docket No.: 25-019020
Case No.: [redacted]
Petitioner [redacted]

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) pursuant to MCL 400.9 and upon a request for hearing.

After due notice, a telephone hearing was held on July 2, 2025, and continued on August 6, 2025. Ashley Kagey, an attorney, appeared on behalf of Petitioner. Susan Richards, Director of Quality Improvement and Compliance, appeared on behalf of the Respondent, Right Door (Department).

Witnesses:

Petitioner	[redacted] Denise Gallady
Department	Melissa Peterson Kris Hamilton Melanie Zalis Kerri Possehn

Exhibits:

Petitioner	1. Miscellaneous Documents 2. Supplemental Brief
Department	A. Hearing Summary

ISSUES

Did Department properly reduce Petitioner's Community Living Supports (CLS) and respite care services?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. As of March 28, 2025, Petitioner was utilizing/receiving 43.75 hours of CLS per week and 86 hours of respite per month. (Exhibit A.)

2. On or around March 28, 2025, a CLS and Respite assessment was completed. At this time, Petitioner was approved for Home Help Services in the amount of 62 hours a month (2 hours a day). (Exhibit A; Testimony.)

3. Following the assessment, Petitioner was scored a 62 based on his goals and level of support needs. (Exhibit A; Testimony.)

4. On March 31, 2025, a CLS and Respite review committee meeting took place. During the meeting, Petitioner was determined to be a category IV with one adult caregiver who lives in the home and who works full/time. (Exhibit A; Testimony.)

5. On March 31, 2025, the Department sent Petitioner an Adverse Benefit Determination. The notice indicated Petitioner's CLS and respite services would be reduced. The noticed stated specifically:

> The clinical documentation provided does not establish medical necessity.
>
> Most recently community living support services assessment dated 3/28/25 recommended 15.5 hours of CLS each week. CLS committee reviewed 3/31/25 and determined [redacted] is eligible for an exception, and is recommended to receive 30 hours of CLS weekly. This is a reduction in CLS hours in comparison with the previous PCP year.
>
> Most recent respite assessment dated 3/28 recommended 8 hours per week of respite supports. This is a reduction in respite services in comparison with the previous PCP year.[1]

6. On April 15, 2025, the Department received from Petitioner, an appeal regarding the March 31, 2025, Adverse Benefit Determination. (Exhibit A.)

7. On May 14, 2025, the Department sent Petitioner an Appeal Denial. The Appeal Denial, upheld the March 31, 2025, determination and provided the following:

> This appeal was requested on 4/15/25 due to a reduction in [redacted] Community Living Support and Respite hours. In [redacted] IPOS in March 2025, his CLS was reduced from 43.75 hours per week down to 30 hours per week. His Respite hours were reduced from 86 hours per month, down to 32 hours per month. Kris Hamilton, MA, LPC, CAADC, MI Clinical Director, The Right Door, reviewed this appeal. Below is her review:

[1] Exhibit A, p 22.

I have been asked by Customer Service at the Right Door for Hope, Recovery and Wellness to provide a clinical review of appeal made by [redacted] mother and legal guardian of [redacted]. He is a 24-year-old male who has Autism Spectrum Disorder. [redacted] is appealing the reduction in CLS hours and appealing the reduction of Respite hours in his most recent Person-Centered Plan…

[redacted] was approved in his 2024 PCP Plan for 43.7 hours per week. In reviewing CLS assessments dated 05/02/2024, he came with an average score of 2.5, which put him at a range of 14-20 hours per month. Given the overall needs of [redacted] at this time, it was agreed to keep him at 43.7 hours/week. In the 2025 PCP Plan, [redacted] was approved for 30 hours/week of CLS. In review of the CLS assessment dated 03/28/2025, there was a modification to the form, allowing for more in-depth review of tasks and definable scoring. This CLS assessment clearly broke down and scored needs on each task. It is noted that Behavior Intervention task was not scored, although [redacted] does have a positive support plan that is presented to BTC quarterly. In talking with case manager Melanie on why Behavior Intervention was not scored, she indicated that this was an oversight, and she scored all of the behavioral needs on the safety task of CLS assessment. So essentially his behaviors were still scored, just in the wrong section. The 2025 CLS assessment showed some improvement, and he scored 15.5 hours/week… The CLS committee convened on this noticeable difference from 2024 to 2025, reviewed his 168-hour schedule, approved MDHHS Home Help Hours, and made a decision to approve 30 hours/week of CLS…

[redacted] does not attend school, although he is eligible until the age of 26. Discussed this with [redacted]. This was a mutual decision between her and the school…

…when a care giver is not providing the care due to own full time employment, being away at that job is its own natural respite…

As mentioned above, it is also not clear as to why section V-nighttime interventions on the Category of Care grid was not considered. If scored, this potentially could warrant an additional 4 hours of needed caregiver break.

It is recommended for approval for 36 hours/month hours of respite care, in support of the defined respite assessment tool in place at TRD, the missed score on the Category of Care grid and to follow

the Medicaid Provider Manual on the intention of this valuable service to care givers.[2]

8. At all times relevant to this issue, Petitioner was eligible for school. (Exhibit A; Testimony.)

9. At all times relevant to this issue, Petitioner's main support is his mother who assists with personal care tasks and community living activities. Petitioner's brother occasionally is able to assist with respite supports and is a paid caregiver through self-directed services. (Exhibit A; Testimony.)

10. Petitioner primarily participates in community living support services in his home and occasionally in his community. Petitioner's mother would like Petitioner to visit more community places if Petitioner were interested. (Exhibit A; Testimony.)

11. On May 23, 2025, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Hearing File.)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.[3]
>
> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other

[2] Exhibit A, pp 32-35.
[3] 42 CFR 430.0.

> applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.[4]

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…[5]

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, this case concerns Community Living Supports (CLS) and respite care services through the Michigan's Habilitation Supports Waiver (HSW).

With respect to the HSW in general, and CLS and respite care services specifically, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid covered state plan services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must

[4] 42 CFR 430.10.
[5] 42 USC 1396n(b).

be specified in their individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The PIHP's enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, does not receive at least one HSW habilitative service per month, withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Division of Adult Home and Community Based Services. (Refer to the Directory Appendix for contact information.) The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services. Reimbursement for services rendered under the HSW is included in the PIHP capitation rate. Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver. Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

* * *

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:

- Meal preparation;

- Laundry;

- Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);

- Activities of daily living, such as bathing, eating, dressing, personal hygiene; and

- Shopping for food and other necessities of daily living.

- Assisting, supporting and/or training the beneficiary with:

- Money management;

- Non-medical care (not requiring nurse or physician intervention);

- Socialization and relationship building;

- Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's

residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);

- Leisure choice and participation in regular community activities;

- Attendance at medical appointments; and

- Acquiring goods and/or services other than those listed under shopping and non-medical services.

- Reminding, observing, and/or monitoring of medication administration.

The CLS does not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping may be used to complement Home Help services when MDHHS has determined the individual's need for this assistance exceeds Home Help service limits. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping, the **beneficiary must request Home Help from MDHHS**. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect their needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS

decision.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory□motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

* * *

Respite care services are provided to a waiver eligible beneficiary on a **short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.** Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between.

- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.

- "Unpaid" means that respite may only be provided during those portions of the day when no one is being

paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports or other services of paid support or training staff should be used. **The beneficiary's record must clearly differentiate respite hours from community living support services.** Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings:

- Waiver beneficiary's home or place of residence.
- Licensed foster care home.
- Facility approved by the State that is not a private residence, such as:
  - Group home; or
  - Licensed respite care facility.
- Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS.

> Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.[6]

Moreover, while CLS and respite care services are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services.[7] Regarding medical necessity, the MPM also provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

[6] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2025, pp 123-125, 139-140.
[7] 42 CFR 440.230.

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

  - that are experimental or investigational in nature; or

  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that

otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.[8]

Here, as discussed above, Department has decided to both reduce Petitioner's CLS and respite services.

In appealing those actions, Petitioner bears the burden of proving by a preponderance of the evidence that Department erred.

Given the record and applicable policies in this case, and for the reasons discussed below, the undersigned Administrative Law Judge finds that Petitioner has not met that burden and the Department's decision should be affirmed.

Petitioner argues that a reduction in CLS and respite services would be detrimental to Petitioner and [redacted] his primary care provider. Petitioner correctly argues that respite is to provide the primary caregiver intermittent short-term relief from the overwhelming daily stress and demands of providing unpaid care. However, Petitioner goes on to argue that the respite services are used to provide relief to the primary caregiver during time periods in which the primary caregiver is working their full-time job away from the Petitioner. And this is where Petitioner's primary argument fails. Respite is for short-term and intermittent use. The primary caregiver's full-time employment is neither short-term or intermittent. Furthermore, the applicable respite policy provides that "[r]espite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work fulltime."[9]

In regard to the CLS reduction, Petitioner failed to present anywhere within the person-centered planning document where hours were needed above and beyond what was approved in order to service Petitioner's needs. Petitioner did throw out a blanket

[8] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2025, pp 13-15.
[9] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2025, p 141.

argument calling for CLS to provide care during time periods in which Petitioner's primary caregiver was working, but that cannot be the case as Petitioner was using respite hours to cover these time periods.

Petitioner did not directly address the issue regarding schooling, or the receipt of Adult Home Help Services. Petitioner, in this case, made the decision not to attend school, a benefit to the Petitioner. Likewise, Petitioner was approved for 62 hours a month of Home Help Services to assist the Petitioner with Activities of Daily Living and Instrumental Activities of Daily Living, areas that are highlighted in Petitioners Person Centered Plan. Simply put, there cannot be a duplication of services; and Medicaid is a payor of last resort, and cannot supplant alternate services such as those offered by the school system.[10]

Based on the evidence, there is sufficient evidence to affirm he Department's decision in this matter. Petitioner may be interested in looking at Overnight Health and Safety Supports (OHSS).[11]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly reduced Petitioner's CLS and respite care services.

IT IS THEREFORE ORDERED that:

The Department's decisions are **AFFIRMED.**

COREY A. ARENDT
ADMINISTRATIVE LAW JUDGE

[10] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2025, pp 124,
[11] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2025, p 130.

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via First Class and Electronic Mail:

Petitioner Representative
ASHLEY KAGEY
BUHL, LITTLE, LYNWOOD & HARRIS, PLC
271 WOODLAND PASS
STE 115
EAST LANSING, MI 48823
AKAGEY@BLLHLAW.COM

Community Health Representative
THE RIGHT DOOR
IONIA COUNTY CMHSP
375 APPLE TREE DRIVE
IONIA, MI 48846
SRICHARDS@RIGHTDOOR.ORG

Via Electronic Mail:

Department Contact
BELINDA HAWKS
MDHHS-BPHASA
320 S WALNUT ST 5TH FL
LANSING, MI 48933
MDHHS-BHDDA-HEARING-NOTICES@MICHIGAN.GOV

Authorized Hearing Representative
[redacted]

Via First Class Mail:

Petitioner
[redacted]