Date Mailed: February 4, 2026
Docket No.: 25-026441, 25-000444, 25-000445
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioners' request for a hearing.

After due notice, a hearing commenced on October 14, 2025, and was continued on November 13, 2025, December 16, 2025, and December 23, 2025. A status conference was held on January 5, 2026, and the record was held open until January 26, 2026, for the parties to submit closing briefs.

Attorneys Simon Zagata and Edward Krugman appeared on Petitioners' behalf.

Evan George, Fair Hearing Officer, appeared on behalf of Respondent, Washtenaw County Community Mental Health. (Respondent, WCCMH or CMH.)

EXHIBITS

Petitioners' Exhibits: A-H

Respondent's Exhibits: Exhibits D001-D084

ISSUE

Whether Respondent established good cause to terminate Petitioners' Self-Determination (SD) service arrangements and associated Fiscal Intermediary (FMS) services.

FINDINGS OF FACT[1]

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

1. Petitioners are Medicaid beneficiaries who have been receiving services through CMH under the Habilitation Supports Waiver (HSW) via a self-determination arrangement. (Exhibits A, B, C.)

2. CMH is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibits A, B, C.)

3. Arrangements supporting self-determination are administrative mechanisms and not covered services. All Medicaid documentation requirements apply to services obtained via SD. Termination of SD/FMS on its own does not change the amount, scope, or duration of Petitioners' CLS authorizations. (Exhibit G pp 2–3, 7–10; Exhibit A p 2; Exhibit B p 2; Exhibit C p 2; Exhibit A pp 8–10.)

4. Prior to October 1, 2025, CMHSP systems utilized a single base CLS code (H2015) that did not differentiate staffing ratios. Providers were still obligated to document services actually provided and, after MDHHS's 2020 guidance, bill appropriately with shared-hour modifiers when applicable. (Tr 11/13 at 6, 11, 82, 94, 98; Tr 12/16 at 17-18.)

5. On March 3, 2025, CMH notified Petitioners' mother and Employer of Record (EOR) that progress notes were "repetitive and/or not shift-specific" and lacked detail supporting billed 1:1 staffing, particularly overnight. CMH met with the EOR on April 2, 2025, supplied standards/examples, and extended the implementation deadline from May 1 to June 1, 2025. (Exhibit D p 1; Tr 12/16 at 5, 8-10; Exhibit D p 5; Exhibit D p 15.)

6. On April 26, 2025, the EOR emailed the CMH, indicating "No clarification and pause of service." On May 27, 2025, the EOR emailed the CMH "I will not sign or do billing till we have an understanding and an agreement." Thereafter, the EOR ceased submitting timesheets and billing for months despite the policy requirement to submit documentation within 30 days of services. (Exhibit D p 14; Exhibit D p 17; Tr 12/16 at 24-25.)

[1] These Findings of Fact are based on the record and anything contrary in Petitioners' proposed Findings of Fact or Conclusions of Law are rejected. The undersigned is also not convinced that the rule cited by Petitioners, R 792.10133, applies to these proceedings because there are more specific rules in Part 10 of the rules, specifically 792.11012 and 792.11013, which apply to MDHHS hearings that cover ALJ opinions and hearing decisions. Those rules do not include a provision regarding proposed findings of fact.

7. As of mid-June 2025, CMH had received no timesheets for April or May and could not determine whether services had ceased or documentation had stopped. (Billing did not resume until October 2025.) (Tr 12/16 at 4, 25; Tr 11/13 at 31; Tr 12/23 at 27.)

8. Where prior timesheets existed, they showed near-exclusive overnight staffing billed as 1:1 (often with multiple caregivers) and repeated notes such as “night supervision,” lacking shift-specific description of supports tied to CLS goals and outcomes or justification for 1:1 or multiple simultaneous staff. (Exhibit A pp 30–37; Exhibit B pp 27–34; Exhibit C pp 30–34; Tr 11/13 at 17, 21–22, 88.)

9. CMH repeatedly asked the EOR to identify how many 1:1 hours were clinically necessary and invited CLS reassessments. The EOR did not specify a number and later withdrew a written request proposing explicit 1:1 and shared allocations. (Exhibit A p 57; Exhibit A p 54; Exhibit B p 45; Exhibit C p 42; Exhibit D003; Exhibit D084.)

10. The EOR’s best friend assisted with employer responsibilities and was related to other CLS staff, presenting conflicts of interest in documentation oversight. CMH noted public social-media posts showing staff apparently out of state when timesheets indicated CLS in the home. (Tr 11/13 at 30-31; Exhibit H p 13; Exhibit D073.)

11. On May 12, 2025, CMH issued formal written notice that Petitioners’ SD arrangements were at risk due to failure to implement MDHHS CLS documentation and billing requirements. On June 9, 2025, CMH issued Advance Action Notices terminating SD/FMS, invoking the SD Agreements, Attachment P4.7.1, and the CMHPSM Self-Directed Services Policy. (Exhibit D pp 15–16; Exhibit A p 2; Exhibit B p 2; Exhibit C p 2; Exhibit A pp 8–10.)

12. MDHHS Bulletins MMP 25-31 BH and MMP 25-41 BH (effective October 1, 2025) provide that beneficiaries may challenge SD termination at Fair Hearing and that the ALJ shall reverse and direct continuation of SD if the proofs do not establish good cause, after considering the following factors: health/safety/legal risk; CMH good-faith problem-solving; ongoing assistance (e.g., staff/budget management/supports broker); adequate training; and written notice that SD is at risk. (MMP 25-31; MMP 25-41.)

13. Given that MPM § 2.5.E.1 places the burden of proof on Respondent in termination of SD cases, that standard will be applied here. As such, Respondent must prove by a preponderance of the evidence that the termination of Petitioners’ SD arrangements was proper. (MPM § 2.5.E.1)

14. Petitioners assert WCCMH attempted to force shared hours, acted in bad faith, provided no training, and misrepresented shared scenarios as "authorized budgets". They argue no non-compliant timesheets were submitted between May 12, 2025, and June 9, 2025, warranting summary reversal. They also contend the IPOS/authorization use of "unspecified," violates PIHP policy requiring delineation of shared vs 1:1 and rely on *In re Wiesner* to limit termination issues. (Exhibit D014, ¶¶ VII.L, VIII.C; Exhibit D064 4 PIHP Policy) ¶¶ VII.L, VIII.C; Exhibit 1; Exhibit D065; Exhibits D011A–C; D010A/C.)

15. On July 23, 2025, Petitioners' requests for hearing were received by the Michigan Office of Administrative Hearings and Rules.

CONCLUSIONS OF LAW

The Medical Assistance Program 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.
>
> *42 CFR 430.0*

> 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 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.
>
> *42 CFR 430.10*

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…

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 (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

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 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
April 1, 2025, pp 13-15

2.5.E.1. ALJ AUTHORITY IN TERMINATION OF SELF-DIRECTED SERVICE ARRANGEMENTS AND CHOICE VOUCHER HEARINGS (Effective October 1, 2026)

Beneficiaries in a SD service arrangement may challenge the termination of the SD service arrangement in a Medicaid Fair Hearing. The ALJ shall reverse, rather than remand, the PIHP's/CMHSP's termination decision and direct the continuation of the SD if the proof presented on the record does not establish good cause to terminate the SD service arrangement. In determining whether there was good cause to terminate the SD service arrangement, the ALJ may consider the following factors, as well as any other factor relevant to the particular case:

- Health and Safety Implications: Consider whether the termination is due to a significant health, safety, and/or legal issue that has and will continue to put the beneficiary's health and safety at risk.

- Problem-Solving Opportunities: Consider whether the required good faith efforts were made to meaningfully problem solve the issues leading to a decision to end the SD service arrangement.

- Support Opportunities: Consider if ongoing support and assistance was provided to the beneficiary to SD their services (e.g., staff management, active budget management, education, services and supports broker).

- Training: Consider if the beneficiary/employer of record was provided with adequate training on SD service arrangements and supports available.

- Written Notice: Consider if the beneficiary/employer of record was provided with the obligatory written notice that the arrangement was at risk of termination.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
January 1, 2026, pp 17-18

For self-determination policy prior to October 1, 2025, see Medicaid Managed Specialty Supports and Services Program FY20, Attachment P11.7.1, MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES Behavioral Health and Developmental Disabilities Administration SELF-DETERMINATION POLICY & PRACTICE GUIDELINE (Exhibit G)

A. Parties Arguments

Respondent argues that its decision to terminate Petitioners' SD arrangements and FMS services was proper and supported by good cause. WCCMH emphasizes that SD arrangements are administrative mechanisms, not Medicaid-covered services themselves, and that termination does not reduce the amount or scope of Petitioners' authorized Community Living Supports (CLS). Instead, it changes the delivery method to ensure compliance with Medicaid requirements.

The Respondent explains that the dispute arose because the EOR repeatedly failed to meet basic obligations under the SD agreements, including submitting shift-specific documentation and maintaining communication. WCCMH identified deficiencies in March 2025, noting that timesheets were repetitive, lacked detail, and did not justify the extensive use of 1:1 staffing – particularly overnight, when Petitioners were likely asleep.

Despite WCCMH's efforts to educate and assist, including providing examples, holding meetings, and extending deadlines from May 1, 2025, to June 1, 2025, the EOR did not correct these issues. Instead, she announced she would pause services and stop billing until her demands were met, resulting in a six-month gap with no documentation or billing, even though at least one Petitioner continued receiving services.

Respondent stresses that Medicaid requires providers to document what services were provided and progress toward goals for each shift. The EOR's failure to submit documentation violated these requirements and prevented WCCMH from monitoring service delivery. WCCMH also points to accountability concerns: the EOR employed her best friend and family members as caregivers, creating conflicts of interest, and social media posts suggested staff were absent during billed hours. These factors, combined with the EOR's refusal to engage in reassessment or specify clinically necessary 1:1 hours, made continued reliance on her as an SD provider untenable.

WCCMH rejects Petitioners' claim that termination was a tactic to force shared staffing. It explains that "unspecified" CLS hours were authorized to allow flexibility for single or shared staffing when appropriate, but the EOR misinterpreted this as blanket approval for 1:1 care without documentation. Respondent further clarifies that SD budgets before October 2025 were estimates, not guarantees, and funds were only available when services were properly documented.

Finally, WCCMH argues that it satisfied all five factors under the new MPM standard: it acted in good faith, provided notice and assistance, offered training, and extended deadlines. The EOR's unilateral decision to stop billing and documentation, coupled with persistent noncompliance and conflicts of interest, constitutes good cause for termination. WCCMH asks the Tribunal to affirm its decision so that Petitioners' CLS services can be delivered through a provider capable of meeting Medicaid standards.

Petitioners argue that WCCMH lacked good cause to terminate their SD arrangements and FMS services. They emphasize that under Medicaid Provider Manual § 2.5.E.1, the burden of proof rests on WCCMH, and if good cause is not established, the Administrative Law Judge must reverse the termination. Petitioners contend that WCCMH failed to meet this standard.

According to Petitioners, the termination notices cited only two reasons: failure to implement MDHHS documentation requirements and failure to implement billing requirements. They assert that these reasons are unfounded because, between the May 12, 2025, warning and the June 9, 2025, termination, no non-compliant timesheets were submitted – in fact, no timesheets were submitted at all because services were paused after staff resigned. Petitioners argue that the absence of documentation during this period cannot constitute a violation since no services were provided for two of the three individuals, and the limited services for [redacted] were provided by his grandmother, who was not billing.

Petitioners claim WCCMH acted in bad faith, using the threat of termination to force shared staffing arrangements instead of the longstanding 1:1 care that had been in place for years. They argue that WCCMH imposed unrealistic deadlines, misrepresented shared staffing as mandatory, and ignored person-centered planning principles. They also allege that WCCMH mischaracterized estimated budgets as "authorized budgets" and refused to approve necessary rate increases for caregivers, which contributed to staff resignations and service gaps.

Further, Petitioners assert that WCCMH provided no meaningful training or support to help them comply with documentation requirements, despite the complexity of Medicaid billing rules. They argue that WCCMH's reliance on the term "unspecified" in the IPOS violated PIHP policy requiring clear delineation of shared versus 1:1 hours. Petitioners maintain that their interpretation – that unspecified meant 1:1 – was reasonable given historical practice and WCCMH's prior acquiescence to 1:1 staffing.

Finally, Petitioners contend that WCCMH's actions caused harm, including behavioral deterioration and hospitalization, and that the agency ignored its obligation to act in the best interests of the individuals served. They urge the Tribunal to reverse the termination, reinstate SD arrangements, and reject WCCMH's arguments as pretextual and unsupported by the record.

B. Governing Framework

Attachment P4.7.1 provides that SD/FMS are administrative arrangements subject to all Medicaid documentation and CMHSP monitoring requirements, and that termination may be initiated after written notice and problem-solving opportunities when compliance fails. (Exhibit G pp 2–10.)

Under MMP 25-31 (codified in MPM § 2.5.E.1), the ALJ shall reverse termination if proofs do not establish good cause, considering health/safety/legal risks, CMH good-faith problem-solving, ongoing assistance/support, training, and written notice. (MMP 25-31; MMP 25-41.)

PIHP/CMHPSM policy requires providers to document for each entry the date, start/stop times, CLS-related goals/objectives supported, and outcomes/progress; CMHSPs must monitor for over-and under-utilization. (Exhibit D064 p 5; see also 42 C.F.R. § 438.330(b)(3).)

C. Application of § 2.5.E.1 Factors

Health/Safety/Legal. CMH did not premise termination on a health/safety crisis. Termination addressed administrative non-compliance with Medicaid documentation/billing requirements. Petitioners' claim that CMH "created," safety issues by insisting on sharing is unpersuasive: the record reflects 1:1 staffing could be used when appropriately documented (e.g., community outings) and WCCMH invited reassessment to justify fixed 1:1 needs, which the EOR declined. (Tr 11/13 at 11, 14; Exhibit D065; Exhibit A p 57.)

Good-Faith Problem-Solving. CMH initiated education in an email dated March 3, 2025, met with the EOR on April 2, 2025, provided written answers and examples, extended the deadline from May 1, 2025, to June 1, 2025, and invited CLS reassessments. The EOR paused services/billing on April 26, 2025, did not specify 1:1 hours (Exhibit A p 57), and later withdrew her own request for assessment (Exhibit D084). On balance, WCCMH's efforts constitute good-faith problem-solving while the EOR's actions thwarted resolution. (Exhibit D pp 1, 5, 12, 15–17; Tr 12/16 at 8–10, 21, 25.)

Ongoing Assistance/Supports. WCCMH provided documentation exemplars and materials, offered further meetings/education, and directed the EOR to coordinate with the Supports Coordinator for reassessments. The FI's role is limited to field checks and processing, with CMHSPs reviewing sufficiency later – underscoring the EOR's duty to submit compliant notes. (Exhibit D pp 1, 5, 18–28; Tr 12/16 at 8–10, 12, 19; Frash Aff. ¶¶ 14, 19.)

Adequate Training. While Petitioners assert there was "no training," the record shows WCCMH furnished written standards and examples and offered in-person follow-up. The baseline obligation to submit shift-specific notes tied to goals/outcomes remained, and the months-long absence of documentation cannot be excused. (Exhibit D pp 18–28; Tr 12/16 at 8–10, 19, 24–25.)

Written Notice. WCCMH issued the May 12, 2025, termination warning identifying documentation/billing deficiencies and the June 9, 2025 Advance Action Notices, providing opportunities and extending time to cure. (Exhibit D pp 15–16; Exhibits A–C p 2.)

D. Response to Petitioners' Arguments

Burden of proof / summary reversal. Petitioners seek summary reversal because no non-compliant timesheets were submitted between May 12, 2025, and June 9, 2025. The argument fails. The EOR's unilateral cessation of documentation/billing – even while services to Avonte continued – violated the SD Agreements (duty to provide documentation; duty to communicate/seek help) and constitutes good cause for termination after problem-solving failed. (Exhibit A p 61–63; Tr 12/16 at 24–25; Exhibit D pp 15–16.)

"Unspecified" vs "Shared" (PIHP policy ¶¶ VII.L; VIII.C). Petitioners contend IPOSs must "delineate" which hours are shared vs 1:1 and that "unspecified," fails this requirement. Pre-Oct. 2025, authorizations uniformly used the base H2015 code without modifiers; providers documented in practice whether hours were single or shared. WCCMH adopted "unspecified/shared" internally to afford flexibility, and repeatedly asked the EOR over a few years to specify 1:1 needs or permit reassessment, which she refused. Petitioners' policy critique does not negate the independent basis for termination – failure to submit sufficient documentation and to engage in reassessment. (Tr 11/13 at 11, 82; Tr 12/16 at 10, 16–18; Exhibits A p 51; D014; D064; D065.)

Alleged "authorized budget" misrepresentation. Petitioners argue CMH misrepresented FI-prepared shared scenarios as "authorized budgets." Pre-Oct. 2025, SD "budgets" were FI estimates derived from base authorizations and rates; funds were available only when services were properly documented, and budgets could be adjusted mid-period. Regardless of labels, the dispositive facts remain the EOR's failure to submit compliant documentation and refusal to cooperate in assessment are facts that establish good cause. (Tr 11/13 at 8–13; Tr 12/16 at 12; Exhibits D065; D010A/C.)

"1:1 is not restrictive" and social-media matters. Whether 1:1 is "restrictive" is immaterial to termination where documentation did not justify near-exclusive overnight 1:1 utilization and multiple simultaneous staff. WCCMH sought clinical reassessment for any defined 1:1 needs, which the EOR declined. Social-media discrepancies were not the sole basis for termination but illustrate accountability concerns within an arrangement lacking independent oversight. (Tr 11/13 at 14, 17, 26–27, 30–31; Exhibit A pp 30–37; Exhibit B pp 27–34; Exhibit C pp 30–34; Exhibit H p 13; D073.)

Reliance on *Wiesner*. Petitioners cite *In re Wiesner*. Since October 1, 2025, MDHHS policy expressly authorizes Fair-Hearing review of SD termination under MMP 25-31; *Wiesner* predates this change and is not controlling on the present question, which is termination of SD/FMS. (Exhibit 1; MMP 25-31; MMP 25-41.)

D. Determination

Applying MPM § 2.5.E.1 and considering the entire administrative record, Respondent established good cause to terminate Petitioners' SD/FMS arrangements. CMH provided notice, education, extended deadlines, and invited reassessment; the EOR ceased documentation and billing, did not specify 1:1 needs, withdrew her own request for defined allocations, and failed to recruit/manage staff as required by the SD Agreements. Where documentation existed, it was not shift-specific and did not justify the billed staffing ratios. Termination of SD/FMS ensures delivery of authorized CLS through a provider capable of meeting Medicaid documentation and oversight requirements. (Exhibit D pp 1, 5, 12, 14–17; Exhibits A–C p 2; Exhibit D064 p 5; Exhibit A pp 30-37; Exhibit B pp 27-34; Exhibit C pp 30-34; Tr 11/13 at 17, 21-22, 30-31; Tr 12/16 at 8-10, 12, 21, 24-25.)

This decision makes no findings regarding Petitioners' needs for 1:1 CLS v. shared CLS as that determination is not before the tribunal. While the undersigned is cognizant of Petitioner's position that the issue of shared CLS led CMH to terminate Petitioners' SD/FMS arrangements, the fact remains that CMH had sufficient reason to terminate the arrangements regardless of the CLS controversy. CMH should immediately conduct a CLS assessment of Petitioners to ensure that they are receiving medically necessary services and that CLS policy is being adhered to.

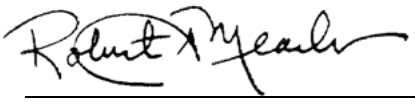
However, based on the evidence presented, CMH's decision was proper and should be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH established good cause to terminate Petitioners' SD/FMS arrangements.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



ROBERT J. MEADE
ADMINISTRATIVE LAW JUDGE

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 LARA-MOAHR-DCH@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 & Electronic Mail:

Petitioner Representative
SIMON ZAGATA
DISABILITY RIGHTS MICHIGAN
4095 LEGACY PKWY
LANSING, MI 48911
SZAGATA@DRMICH.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

Petitioner Representative
EDWARD P. KRUGMAN
LAW OFFICE OF EDWARD P. KRUGMAN
247 W 12TH ST PH A
NEW YORK, NY 10014-1992
EPK@EPKLAW.NET

Respondent
WASHTENAW COUNTY CMH
EVAN GEORGE
555 TOWNER
YPSILANTI, MI 48197
GEORGEE@WASHTENAW.ORG

Via First Class Mail:

Petitioners
[redacted]
MI [redacted]