FOR DEPARTMENT USE ONLY

State of Hawaii

Date Request was Received: _____

DEPARTMENT OF HUMAN SERVICES, Social Services Division

ADULT & COMMUNITY CARE SERVICES BRANCH

Name of Worker and Phone Number: _____

ACCSB Unit Name and Address: _____

_____

_____

REQUEST FOR ADMINISTRATIVE HEARING
ADULT PROTECTIVE SERVICES

Print your Name and Mailing Address: _____

_____

_____

I would like an Administrative Hearing because I do not agree with the decision of the Adult Protective Services (APS) investigation.

You have the right to identify someone to be your Authorized Representative to represent you in the Administrative Hearing. If this is what you want, complete the sentence below.

I want _____

Print the Individual's Name and Mailing Address

as my Authorized Representative to represent and act for me in this Administrative Hearing.

IF YOU WANT AN ADMINISTRATIVE HEARING:

You <u>must sign</u> this form to complete your request for an Administrative Hearing and you <u>must return</u> this form to the Adult & Community Care Services Branch Unit Office that is listed above <u>within 90 calendar days</u> of the date of the <u>DHS 1636</u>, "Notice of Disposition, Adult Protective Services", informing you of your being a confirmed perpetrator.

_____ _____

Your Signature *Date*