APPEAL FORM

ND DEPARTMENT OF HUMAN SERVICES/Aging Services

SFN 747 (10-2007)

Clear Fields

TO: North Dakota Department of Human Services Capitol Building - Judicial Wing 600 E Boulevard Ave Dept 325 Bismarck, North Dakota 58505-0250 ATTN: Appeals Officer		
FROM Name:		
Street Address:		
City:	State:	Zip Code:
Telephone Number:		

REQUEST FOR AN ADMINISTRATIVE HEARING
REGARDING THE (DENIAL/REVOCATION) OF A LICENSE
TO PROVIDE ADULT FAMILY FOSTER CARE

I, _____, have been licensed or have applied to be licensed for Family Foster Care for Adults at _____.

The Department of Human Services has notified me of their intent to (deny/revoke) my license on (Date you received notice) _____. I do not agree with this action of the Department of Human Services and I request an administrative hearing for the following reasons: (State reasons you are appealing) _____

Signature of Appellant:	Date Signed: