

OSAH FORM 1

This form is available online at <http://www.osah.ga.gov/> or by telephone request at (404) 657-2800.

OSAH USE ONLY DOCKET NUMBER:	AGENCY DBHADD	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE
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DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

Non-Agency Party County of Residence:	*Expiration Date (required)	Date Request for Hearing Filed with Agency:	Agency Case Number:
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Check Here if an Application Was Denied: <input type="checkbox"/>	
Check Only One in This Box:	
<input type="checkbox"/> CER (Clinical Evaluator Registry) <input type="checkbox"/> COC (Cost of Care) <input type="checkbox"/> DUJIRISK (Reduction of Certification Cases Administered By DDS) <input type="checkbox"/> ICFMR (Intermediate Care Facility For The Mentally Retarded Regulatory And/Or Civil Penalties) <input type="checkbox"/> JLJR (Child Involuntary Treatment-Inpatient Hospitalization Required Hearing) <input type="checkbox"/> MIH (Mental Illness Hearings Relating to a Treatment Facility's Request to continue involuntary treatment of a hospitalized patient beyond the end of the period during which the Treatment Facility is currently authorized to retain the patient) <input type="checkbox"/> MIR (Mental Health Desk Review)	<input type="checkbox"/> MRH (Mental Retardation Hearings Relating to A Treatment Facility's Request to continue involuntary habilitation beyond the end of the period during which the Treatment Facility is currently authorized to retain the client) <input type="checkbox"/> MRR (Mentally Retarded Desk Review, Continued Habilitation) <input type="checkbox"/> NOW/Comp Waiver (MRWP Waiver) <input type="checkbox"/> OA (Olmstead Appeals) <input type="checkbox"/> OUTPATH (Outpatient Hearing, Mentally Ill Person Requiring Involuntary Outpatient Treatment) <input type="checkbox"/> OUTPATR (Outpatient Desk Reviews, Mentally Ill Person Requiring Involuntary Outpatient Treatment) <input type="checkbox"/> PRTF/CBAY Waiver (Psychiatric Residential Treatment Facility/Community Based Alternative for Youth) <input type="checkbox"/> SA (Substance Abuse Continued Hospitalization) <input type="checkbox"/> SDC (Setoff Debt Collection (BHADD))

CONTACT PERSON IN AGENCY

NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE ON HEARING REQUEST	POSITION	EMAIL

NON-AGENCY PARTY

NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE		EMAIL
<input type="checkbox"/> ATTORNEY <input type="checkbox"/> PERSONAL REPRESENTATIVE NAME (IF APPLICABLE)	TEL NO	FAX NO
ADDRESS INCLUDING ZIP CODE	GEORGIA BAR NO	EMAIL
1st REPRESENTATIVE	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	RELATIONSHIP TO PATIENT OR CLIENT	EMAIL
2nd REPRESENTATIVE	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	RELATIONSHIP TO PATIENT OR CLIENT	EMAIL

AGENCY PARTY

NAME AND TITLE OF CONTACT IN OFFICE	DIRECT TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	EMAIL	
ATTORNEY NAME (IF APPLICABLE)	TEL NO	FAX NO
ADDRESS INCLUDING ZIP CODE	EMAIL	GEORGIA BAR NO