AGENCY/INDIVIDUAL FOSTER CARE APPEAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES
SFN 747 (3-2023)

☐ Agency Foster Home
☐ Adult Foster Care

TO: Department of Health and Human Services
Capitol Building - Judicial Wing
600 E Boulevard Ave Dept 325
Bismarck, North Dakota 58505-0250
ATTN: Appeals Supervisor

FROM: (Name)			Telephone Number
Address	City	State	ZIP Code

**REQUEST FOR AN ADMINISTRATIVE HEARING
REGARDING THE (DENIAL/REVOCATION) OF A LICENSE
TO PROVIDE AGENCY/INDIVIDUAL FOSTER CARE**

I have been licensed or applied to be licensed for Agency/Individual Foster Care at the above address. The Department of Health and Human Services has notified me of their intent to deny/revoke my license on:

Date Notice Received

I do not agree with this action of the Department of Health and Human Services and I request an administrative hearing.

Specify Reason(s) You Are Appealing

**** Written request for appeal must be filed within twenty (20) calendar days of your receipt of this notice. ****

Signature of Applicant	Date