



**ADULT FOSTER CARE APPEAL**  
 NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
 AGING SERVICES DIVISION  
 SFN 747 (3-2017)

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

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

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

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

Specify Reason(s) You Are Appealing
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**\*\* Written request for appeal must be filed within twenty (20) calendar days of your receipt of this notice. \*\***

Signature of Applicant	Date
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