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	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE
	DBHDD				

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:

Check Here if an Application Was Denied: ☐

Check Only One in This Box:

☐ CER (Clinical Evaluator Registry)
☐ COC (Cost of Care)
☐ DUIRISK (Reduction of Certification Cases Administered By DDS)
☐ ICFMR (Intermediate Care Facility For The Mentally Retarded Regulatory And/Or Civil Penalties)
☐ JLJR (Child Involuntary Treatment-Inpatient Hospitalization Required Hearing)
☐ 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)
☐ MIR (Mental Health Desk Review)
☐ 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)
☐ MRR (Mentally Retarded Desk Review, Continued Habilitation)
☐ NOW/Comp Waiver (MRWP Waiver)
☐ OA (Olmstead Appeals)
☐ OUTPATH (Outpatient Hearing, Mentally Ill Person Requiring Involuntary Outpatient Treatment)
☐ OUTPATR (Outpatient Desk Reviews, Mentally Ill Person Requiring Involuntary Outpatient Treatment)
☐ PRTF/CBAY Waiver (Psychiatric Residential Treatment Facility/Community Based Alternative for Youth)
☐ SA (Substance Abuse Continued Hospitalization)
☐ SDC (Setoff Debt Collection (BHADD))

NON-AGENCY PARTY

NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE		EMAIL
☐ ATTORNEY ☐ 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

SERVICE OF DOCUMENTS: In additional to routine service on the agency's attorney, the agency contact person requests the following:

☐Service of all documents prior to certification of the file to the agency after a decision
☐Service of a copy of the notice of hearing
☐Service of a copy of a continuance
☐Service of copy of any interim orders
☐Service of a copy of decision

All documents will be mailed to the referring agency at the address indicated for the contact person to the contact person's attention unless written instructions provide an alternative place for service.