

**Substance Use Disorder
ABILITY TO PAY
ADMINISTRATIVE HEARING DISPOSITION FORM**

Consumer Name: _____

Responsible Party: _____

Administrative Hearing Date: _____

Hearing Type: Face to Face Telephone: _____

Persons Attending Meeting: _____

Current Consumer Complaint(s): _____

Agency Response: (Attach more paper if necessary):

Meeting Disposition:

Resolved Withdrawn Pended Not Resolved

Disposition Discussion: _____

Region 10 Hearing Officer Signature

Consumer/Responsible Party Signature

Cc: Case Record
Region 10 SUD Director