Access Eligibility Services
APPEAL INFORMATION FORM

If you disagree with your eligibility determination for Access Paratransit you have the right to appeal this decision within **60 days**. Your original eligibility determination will remain in effect until a final decision is made and your appeal is closed.

Please return your completed Appeal Information Form to:

Access Eligibility Services Appeal
P.O. Box 71684
Los Angeles, California 90071

**Please Clearly Print or Type**

ID Number: _________________________________
Last Name: _________________________________
First Name: _________________________________
Address:     _________________________________
City & Zip:  _________________________________
Telephone Number: (_____) ____________________  Daytime
            (_____) ____________________  Evening
What is your disability?  ________________________________
                                                                 ___________________________________________________________________
                                                                 ___________________________________________________________________
                                                                 ___________________________________________________________________
                                                                 ___________________________________________________________________
Please explain why you think the transit evaluation decision is incorrect and why you cannot use the bus?
                                                                 ___________________________________________________________________
                                                                 ___________________________________________________________________
                                                                 ___________________________________________________________________
                                                                 ___________________________________________________________________
                                                                 ___________________________________________________________________
Do you use a mobility device?  □ Yes  □ No
If Yes please describe: ____________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

I certify that the information I gave is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential and only the information required to provide the services I request will be disclosed to those who perform those services.

Appellant signature: ______________________________________________
Date: ____________________

Person, Other Than Appellant, Completing Form

I certify that the information provided in this questionnaire is true and correct based upon information given me by the appellant or based upon my own knowledge of the appellant’s disability.

Print Name: ________________________________________________________
Signature: __________________________________________________________
Date: ________________
Relationship to Appellant: __________________________________________
Address: ___________________________________________________________
Telephone: (____) _____-__________