ACCESS SERVICES APPEAL FORM

You can request an appeal within 60 days from the date of your determination letter. Please print clearly and provide the following information below.

ID Number: ____________________________

Full Name: ____________________________

Address: ________________________________ Zip: ___________

City: __________________ State: ________

Primary #: (_____ ) - Alternative #: (_____ ) -

Mobility Device? ☐ Yes If yes, what type: __________

Describe your disability: (please write on reverse if needed)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Explain why you think the transit evaluation decision is incorrect. (Optional)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature: __________________________ Date: __________

Person Completing Form (other than appellant)

Full Name: __________________________ Relationship: __________________

Address: ______________________________

City: __________________ State: ________ Zip: __________

Primary #: (_____ ) - Alternative #: (_____ ) -

Signature: __________________________ Date: __________

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ATTN: Appeals
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Email: EligDept@accessla.org