

## **ACCESS SERVICES APPEAL FORM**

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

ID Number: \_\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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: \_\_\_\_\_

**Mail to: Access Services  
ATTN: Appeals  
P.O. Box 5728, El Monte, CA 91734  
Email: EligDept@accessla.org**