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

Access Services is a public entity.