APPEAL

Name and address of the welfare office, HMO, CCIS, or other agency that made the decision:

I request a face-to-face hearing to appeal the decision made by the welfare office, HMO, CCIS, or other agency.

I am appealing this decision because I disagree with the decision to:

- ☐ *Deny my application for* _____ *benefits.*
- ☐ *Deny my request for* _____.
- ☐ *Reduce or cut off my* _____ *benefits.*
- ☐ *Other* (explain):

☐ *I received a notice of this action, dated* _____.

☐ *I did not receive a notice of the agency's action.*

☐ *I need a translator in* _____ *language.*

I understand that you will let me know the date and time for the hearing.

_____ Date Signed

_____ Signature of Client

_____ Record Number or Social Security Number

_____ Name of Client

_____ Street Address

_____ City Zip Code

_____ Signature of Person Acting on Client's Behalf

_____ Date Signed

_____ Name of Client's Representative

_____ Address of Client's Representative