Attachment 9-3
Sample ADA Paratransit Eligibility Determination Appeal Request Form

Please complete this form if you would like to appeal our determination regarding your eligibility for the [name of complementary paratransit service]. Once completed, please return it to the address listed below. Completed forms must be postmarked within 60 days of the date of your eligibility determination letter.

Name: _____

Street address: _____

City: _____ State _____ Zip _____

Telephone number with area code: (_____) - _____

Select one of the following:

____ I choose to submit additional information for the Appeal Panel to consider, but do not want to appeal in person. (If you choose this option, please send all additional information you would like the Appeal Panel to consider along with this form. Please consider the information on the page attached to your letter of determination titled "Basis for the Determination" when preparing additional information.)

____ I choose to appeal in person. (If you choose this option, we will contact you to schedule a mutually agreeable day and time for the appeal hearing. You may bring additional information to the hearing and can attend with others who are able to provide information on your behalf.)

Applicant signature: _____

Date: _____

Return completed form to:

[Office]
[Transit agency]
[Address]