APPEAL FORM FOR DENIED DISBURSEMENT REQUEST

Empowering individuals with disabilities to live their fullest life. John 10:10

Please complete this form if your Disbursement Request has been denied and you have additional information or documentation which should be reviewed for reconsideration of prior decision. Form must be submitted within **15 days** of the date of notification indicated on the Denied Disbursement Request Form.

BENEFICIARY NAME:		**ACCOUNT NUMBER:**	

Disbursement Request Being Appealed

Beneficiary Advocate who completed form: _____ Date of Request: _____

Reason for Disbursement Request: _____ Amount Requested: _____

Reason given for denial: _____

Please explain why you think the decision should be overturned and attach any additional required information which will help support your request.

_____

_____

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_____

OFFICE USE ONLY	
Additional Documents Provided: _____	
Appeal Granted: ☐ Yes ☐ No Reason: _____	
Authorized By: _____	Date: _____

"My purpose is to give life in all its fullness" – John 10:10

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