Mercer County Community Transit

REQUEST FOR APPEAL – MCCT ADA ELIGIBILITY DETERMINATION

You have the right to appeal the determination of your eligibility for the MCCT ADA Program. Your request that your case be reviewed must be made within sixty (60) days of the date of your eligibility determination. In order for your appeal to be considered, this form must be returned, postmarked on or before ______________________. Your request will not be considered if postmarked after this date.

(PLEASE PRINT)

Name____

Address________________________ Phone(H)____________ (W)____________

City______________________________ State________ Zip Code____________

Designated advocate, if any ____________________ Daytime Phone________________

This is to certify that I disagree with the decision regarding my ADA eligibility and wish to appeal the decision. I understand my appeal will include the right to appear and be heard in person by the appeal committee.

______________________________________ ____________________

Signature Date

If the application has been completed by someone other than the applicant, please complete the following:

Name____

Address____

City______________________ State__________ Zip Code__________________

Daytime Phone________________ Relationship to Applicant____________________

______________________________________ ____________________

Signature Date

Return this completed form by mail to: MCCT – ADA Eligibility Section
5200 Virginia Road
Hermitage, Pa 16148

If you wish to provide additional information at this time, it is optional. You are not required to complete this section.

You may submit any written materials regarding your disability and your functional ability to use MCCT bus service as part of this appeal. Any written material that you submit will become part of your eligibility file. You may also submit a letter with supporting information from an agency of which you are a client, if you wish.

1. Please explain why you disagree with the decision made concerning your MCCT eligibility. (You may use the other side or additional pages if you need more space.)

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2. Is there any information that was not presented in your original application which you would like to present and have considered? (This may include, but is not limited to current information from your physician, a family member or an agency from which you receive service.) Please check:

   ________ I have attached additional information from: (Please List)

   ____
   Name Address

   ____
   Name Address

   _______ I have no additional information to submit.

   I understand that the above information and my application file will be made available to the members of the Appeal Committee for their consideration. I certify that the information I have provided is correct.

   ____
   Signature Date

   If this section has been completed by someone other than the person requesting review, please complete the following:

   Name__________________ Relationship to Applicant______________________________

   Address____

   City________________ State_______ Zip__________ Daytime Phone___________________

   ____ __________________________
   Signature Date