District of Parry Sound Social Services Administration Board

CHILD CARE RESOURCES CWELCC APPEAL FORM

This form is to be completed by an Operator and returned to the DSSAB electronically via email to ccsm@psdssab.org.

PROGRAM:

Indicate Operator

_____

CONTACT INFORMATION

CONTACT NAME:		POSITION:	
PHONE NUMBER:		EMAIL:	

REASON FOR APPEAL REQUEST:

Original Decision details:	Date original decision communicated to Operator:
Reason for Appeal (please check the applicable box.)	☐ DSSAB did not apply policy or process consistently ☐ DSSAB did not apply policy or process appropriately ☐ Expense is outside of the Operator's control and Operators ability to pay ☐ Operator disagrees with the decision of the DSSAB pertaining to eligible costs (Attributable, Appropriate, Reasonable) ☐ Operator disagrees with the decision of the DSSAB pertaining to the amount repayable for year-end reconciliation ☐ Other (please provide details)
Details: (Please provide a brief explanation of the rationale for the Appeal reason)	

Supporting Documents: (Please indicate what supporting documents you are referencing and/or including to support the Appeal request)	

AUTHORIZATIONS:

I authorize I am able to sign for the organization.

CONTACT NAME AND TITLE:	
SIGNATURE:	
DATE:	

For office use only - DSSAB RESPONSE: