



CHILD CARE SERVICE MANAGEMENT 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.)	<input type="checkbox"/> DSSAB did not apply policy or process consistently <input type="checkbox"/> DSSAB did not apply policy or process appropriately <input type="checkbox"/> Expense is outside of the Operator’s control and Operators ability to pay <input type="checkbox"/> Operator disagrees with the decision of the DSSAB pertaining to eligible costs (Attributable, Appropriate, Reasonable) <input type="checkbox"/> Operator disagrees with the decision of the DSSAB pertaining to the amount repayable for year-end reconciliation <input type="checkbox"/> 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)	
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AUTHORIZATIONS:

I authorize I am able to sign for the organization.

CONTACT NAME AND TITLE:	
SIGNATURE:	
DATE:	

<i>For office use only - DSSAB RESPONSE:</i>