

NUTRITION SERVICES DIVISION / PROGRAM INTEGRITY UNIT APPEAL REQUEST

I. Agency Information:

A. Legal Name of Agency: _____

B. Mailing Address: _____

City, State, Zip: _____

C. CNIPS ID or Vendor Number: _____

II. Statement of Purpose:

A. Type of appeal requested: (Check one box)

☐ Written Review

☐ Oral Hearing

☐ Written Review with Oral Argument

B. Specifically, what is the finding (or findings) being appealed?

C. What is the basis (reason) for the appeal?

III. Background Information:

(Explain the events that led up to your decision to appeal the action taken against you.)

IV. Oral Hearing Only or Written Appeal with Oral Argument

If an **oral hearing** or a **written appeal with oral argument** is requested, please complete the following:

A. Representative

(Name of person who will be officially representing the agency at the hearing):

Name: _____ Title: _____

Mailing Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Does this representative have a legal background? Yes No

If yes, please describe:

V. Contact

Person to contact for information regarding this appeal:

Name: _____ Title: _____

Mailing Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

VI. Evidence:

You may submit written documents/evidence to the hearing officer by attaching it to this appeal request or by sending it under separate cover. (Note: If sent separately, you must adhere to the deadline for submittal and send to the Office of Administrative Hearings as noted in the Appeal Procedures.)

VII. Signature of Authorized Representative

Signed: _____ Date: _____

Name of Authorized Representative: _____

Email the completed Appeal Request to: CACFPappeals@dss.ca.gov