



Supports to Encourage Low-income Families
P.O. Box 1322
Hamilton, Ohio 45012
513-868-9300

Client Appeal Form

Name of client: _____

Address: _____

(City) (State) (Zip)

Phone Number: _____ Email Address: _____

Date of service denial: _____

Type of service(s) denied: _____

PLEASE NOTE:

*An appeal **cannot** be filed if you do not meet income eligibility guidelines and/or if there is a lack of available funds to assist you. You **have the right to appeal** for all other reasons.*

State your reason for appealing here (use the back page if additional space is needed):

Please direct appeals to the Community Relations Coordinator

Client signature _____ Date _____