



HOOPA VALLEY TRIBAL TANF PROGRAM
 PO Box 728, Hoopa, California 95546
 530-625-4816 phone/530-625-4826 fax

REQUEST FOR APPEAL

Note: This form is to be completed only if you have completed the Fair Hearing Process. Any requests shall be denied automatically for failure to complete the Fair Hearing Process.

Date: _____

Name: _____

Phone# _____

Address: _____

Please mark all boxes that apply: Cash Aid

Family Eligibility

1. Please state your reason for the appeal.

2. Please describe any new circumstances or information that was not provided at the Fair Hearing.

3. Please attach any supportive documentation and/or any new additional information regarding your request for service.

 Client Signature

 Date

HVTTTP USE ONLY

 Date Received

 Received By

 Case Worker Name