

Client Name: \_\_\_\_\_

Client ID: \_\_\_\_\_

### **NOTICE OF RIGHT TO APPEAL**

Under the provision of the Americans with Disabilities Act (ADA), you have the right to appeal a determination of ineligibility for ADA Paratransit Service or any restrictions or conditions that are placed upon your use of ADA Paratransit Service. If you wish to make an appeal, please complete this form, and return it to:

Paratransit Director  
Broward County Transportation Department  
1 N. University Dr. Suite 2400-B  
Plantation, FL 33324

Appeals must be filed in writing within **sixty (60) days** from the date of denial. If the sixtieth (60th) day is on a weekend or legal holiday, an appeal will be accepted on the next subsequent business day. Untimely appeal requests will not be processed.

Appellants are urged to state in their written appeal the reasons why the determination does not accurately reflect their ability to use the fixed-route bus service, or why the eligibility conditions are inappropriate. Appellants are requested to provide additional documentation to support their position. Upon receipt of this form with the supporting documentation attached, county staff will review your statements and information on an informal level. This may also involve the request for additional medical information and/or investigative efforts to resolve the appeal on an informal level.

If the matter cannot be resolved at the informal level, the appellant may request the appeal to be reviewed at a formal level before the ADA Paratransit Eligibility Appeals Board. If the appellant intends to introduce additional written information or have individuals present on their behalf at the hearing, the appellant **MUST** provide copies of this information and a witness list to BCT at the above address at least **five (5) days** prior to the scheduled appeal hearing.

If you have any questions regarding the appeal process, please call the BCT Paratransit office at: **954-357-8405**

### **REASON TO REQUEST APPEAL:**

I wish to appeal the determination of my ineligibility for ADA Paratransit service or restricted/conditional eligibility for the following reasons:

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

(Use additional sheets and provide supporting information as needed)