



REQUEST FOR AN APPEAL

Indicate which step you are requesting:

Step One (no fee)

Step Two (see current fee schedule)

Step One Appeal Decision Date: _____

Property Tax Account Number or Facility Name (If applicable): _____

Property/Facility Address:

_____ City, State, Zip: _____

Appellant's Name: _____ Phone: _____

Appellant's Address: _____ City, State, Zip: _____

Appellant's Email Address: _____

Date of decision: _____

Do you request a meeting with the reviewer? Yes No

Appellant: Please attach an additional page(s) stating the details of your appeal. As required per SCBHC 1.20.060(C), required items include: the decision being appealed, the reason you are appealing it, and the regulations which you believe have not been followed or correctly interpreted. Please provide evidence or justification to support your appeal.

Appellant's Signature

Date

FOR HEALTH DEPARTMENT USE ONLY

Service Request Number: _____

Is the Step 1 appeal request made within 21 days of the decision? Yes No

Is the Step 2 appeal request made within 14 days of the Step 1 appeal decision? Yes No

Employee Initials and Date: _____