



APPEAL REQUEST FORM

Formal Appeal Submission for Local Competition and Funding Decisions

APPLICANT INFORMATION

Agency Name: _____
Project Name: _____
Applicant Representative: _____
Title: _____
Organization Address: _____
Email Address: _____
Phone Number: _____
Date Appeal Submitted: _____

BASIS FOR APPEAL

If your agency wishes to appeal a decision, please review the Missouri Balance of State Continuum of Care Appeals Policy, which is posted with the local competition materials. Any appeal submitted must clearly identify the specific section of the Appeals Policy that serves as the basis for the appeal and provide supporting documentation, as applicable.

Appeals must be submitted within two business day following the project's funding recommendation notice by the CoC. An appeal received after the appeal deadline will not be reviewed or considered. Failure to follow the appeal procedure will result in denial of the appeal.

Please ensure that your appeal includes a detailed explanation of how the circumstances of your appeal meet the criteria outlined in the policy.

REASON FOR APPEAL

Please explain the basis for the appeal in detail, consistent with the CoC's appeals policy. Include relevant names, dates, and supporting facts.

SUPPORTING DOCUMENTATION

List all supporting documents attached to this appeal:

REQUESTED RESOLUTION

Describe the action being requested:

CERTIFICATION

I certify that the information contained in this appeal is true and accurate to the best of my knowledge.

Signature: _____

Printed Name: _____