## REQUEST TO APPEAL DETERMINATION/CUSTOMER COMPLAINT

Today's Date:	<u>-</u>
Name:	Phone:
Address:	City/State/Zip:
Is this action a (check one): Complaint _	Appeal
Which program or employee is this documentation referring to?	
Please describe appeal/complaint (use back of form if needed):	
I consent to release any and all information necessary for the determination of my appeal/complaint to be made on my behalf, to the Oneida Center for Self Sufficiency. I understand this release may include, but is not limited to, any information regarding income, salary, benefits, and disability. I certify that all the information provided is true to the best of my knowledge.	
Signature of customer completing this form:	Date
Please return to:  Oneida Economic Support Services  P O Box 365  Oneida, WI 54155	
Jileida, Wi	OT 100

Description of appeal/complaint continued:	
Office Use Only	
Office Use Only:	Forwarded to
Date received:	Forwarded to: