

ELCFV Office use only:

Date: _____ approved: _____ denied: _____

Staff: _____



CHILD CARE SERVICE REQUEST FOR DUE PROCESS

A REQUEST FOR A DUE PROCESS REVIEW MUST BE SUBMITTED WITHIN 14 DAYS FROM THE DATE OF THE DETERMINATION DECISION BEING DISPUTED.

**PLEASE FILL IN THIS FORM COMPLETELY. INCOMPLETE REQUESTS WILL NOT BE PROCESSED.
PLEASE ALLOW 14 DAYS FOR PROCESSING**

**TO REQUEST A DUE PROCESS REVIEW PLEASE COMPLETE THIS FORM
AND FAX, MAIL OR DROP OFF TO:**

FAX: 386-238-4808

ELCFV
135 Executive Circle
Daytona Beach, FL 32114
Or
1205 S. Woodland Blvd
Deland, FL 32720

**IF YOU NEED ASSISTANCE WITH COMPLETION OF THIS FORM, PLEASE CONTACT THE LOCAL OFFICE AT:
386-323-2400**

Toll Free at: 1-877-ELC-0065



WWW.ELCFV.ORG



CHILD CARE SERVICE REQUEST FOR DUE PROCESS

CUSTOMER NAME (PLEASE PRINT): _____ DATE: _____

ADDRESS: _____
STREET/P.O. BOX NO. CITY STATE ZIP CODE

TELEPHONE NUMBER: _____ COUNTY OF RESIDENCE: _____

PLEASE STATE IN DETAIL WHY YOU DISAGREE WITH THE DECISION MADE BY ELCFV STAFF REGARDING YOUR ELIGIBILITY FOR CHILD CARE BENEFITS. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)

PLEASE IDENTIFY THE DATE OF THE DISPUTED ACTION: MONTH _____ DAY _____ YEAR _____

PLEASE IDENTIFY EACH SUPPORTING DOCUMENT ATTACHED TO THIS REQUEST AND ITS PURPOSE TO THE SUBJECT MATTER OF YOUR REQUEST. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)

EXAMPLE: Fax confirmation page	PURPOSE: I did fax my documents on time. I am submitting a fax confirmation page I received.
DOCUMENT:	PURPOSE:
DOCUMENT:	PURPOSE:
DOCUMENT:	PURPOSE:
DOCUMENT:	PURPOSE:
DOCUMENT:	PURPOSE:

ELCFV WILL ONLY BEGIN ASSISTING WITH CHILD CARE SERVICES UPON APPROVAL OF SUBMITTED REQUEST AND SUCCESSFUL COMPLETION OF AN ELIGIBILITY INTERVIEW.

SIGNATURE OF CUSTOMER DATE

SIGNATURE OF AUTHORIZED REPRESENTATIVE, IF APPLICABLE DATE