



Request for Review

Name:	TWIST ID:	Decision Date:
Services were denied, reduced, suspended, or terminated due to: <input type="checkbox"/> Income Requirement <input type="checkbox"/> Absences <input type="checkbox"/> Hour Requirement <input type="checkbox"/> Failure to redetermine eligibility <input type="checkbox"/> Other: _____		
<p>You have the right to a review of Workforce Solutions’ decision to deny/reduce or discontinue your financial aid. We must receive your written request to review the decision within 14 days of the date on this letter. You may email, mail, or fax your request and supporting documents to:</p> <p>Workforce Solutions – FASC Attn: Financial Aid Review PO Box 924586 Houston, TX 77292 Fax: 713.222.2222 Email: supportcenter@wrksolutions.com</p>		

****You do NOT need to complete this form if you are providing requested documents by the deadline.**

Explain why you feel Workforce Solutions’ decision to deny, reduce, or discontinue your financial aid is unfair or unjust. You may include additional pages if the space below is not sufficient.

Are you submitting supporting documents you believe are relevant? Yes No

We will send you our decision within 15 days of date we received your request. If we are unable to resolve your issue, a Board Review will be scheduled.

Signature: _____ Date: _____

Printed Name: _____