



Maine Department of Labor
Paid Family Medical Leave Program
Appeals Unit

NOTICE OF REQUEST TO APPEAL



A copy of the Notice setting forth the decision you are appealing MUST accompany this form. If filing through the Maine Paid Leave Portal, you will select the Notice/Letter being appealed eliminating the need to upload the document.

<u>Notice/Letter Being Appealed:</u>	<u>Notice/Letter ID Number:</u>	<u>Date of Notice/Letter:</u>
<u>Name of Person or Employer Filing Appeal (Appellant):</u>	<u>Account Number if Employer/Self-Employed Individual:</u>	<u>FEIN or Social Security Number:</u>
<u>Mailing Address:</u>	<u>Email Address:</u>	<u>Phone Number:</u>

Do you need any accommodations? Yes ☐ No ☐

If yes, please explain in the box below what is needed including your preferred language if an interpreter is requested.

Requested accommodations (interpreter; in-person hearing; presence of an advocate or other support person):

ADDITIONAL INFORMATION

Please tell us why you disagree with the decision you are appealing.

I request a hearing on my appeal of the determination contained in Notice/Letter No. [Number] issued on [Date].

Date of Request:

Appellant's Signature: