

**ARIZONA DEPARTMENT OF
ECONOMIC SECURITY**
Appellate Services Administration
Telephone: 602-514-4600 •
Fax: 602-257-7055
1990 W Camelback Rd Suite 200
• Phoenix, AZ 85015

Email Address: oigasaappeals@azdes.gov

APPEAL REQUEST

STATE OF ARIZONA
ARAP (Arizona Rental Assistance Program)
LIHEAP (Low Income Home
Energy Assistance Program)

APPELLANT INFORMATION

Appellant Name (*Last, First, M.I.*):

Social Security Number of Appellant:

Are you the: Tenant Landlord

Address of Rental Property (*No., Street*):

City: _____

State: _____ **ZIP Code:** _____

See page 6 for EOE/ADA disclosures

LANDLORD INFORMATION

Name of Landlord (*Last, First, M.I.*): _____

Address (*No., Street*): _____

City: _____

State: _____ **ZIP Code:** _____

Telephone Number: Home _____

Cell _____

LEASE INFORMATION

Name of Primary Lease Holder (*Last, First, M.I.*): _____

Telephone Number: Home _____

Cell _____

Mailing Address if different from Rental (*No., Street*): _____

City: _____

State: _____ **ZIP Code:** _____

Number of people on the lease including lease holder: _____

Names of additional tenants (*First, Last*):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Does anyone receive any other rental assistance? Yes No

If yes what program(s):

Has anyone in the household been impacted by COVID? Yes No

Is anyone in the household qualified for unemployment benefits? Yes No

Do you need an interpreter? Yes No

What Language? _____

Do you need assistance because of a disability? Yes No

Explain:

Representation: Complete this section if you would like for another person to represent you for the hearing.

Representative's Name:

Address (No., Street):

City: _____

State: _____

ZIP Code: _____

Telephone Number: _____

Does this person need an interpreter?

Yes

No

What Language? _____

Does this person need assistance because of a disability? **Yes** **No**

Explain:

Which notice are you appealing?

Date: _____

Application Type: (Check All that apply)

Rental Assistance

LIHEAP

Other

Application ID: _____

Application Date: _____

Tell us the reason for your appeal:

Signature of Appellant or your

Representative: _____

Date: _____

**Name of the person who filled out this
appeal request:**

**Equal Opportunity Employer / Program •
Auxiliary aids and services are available
upon request to individuals with disabilities
• TTY/TDD Services 7-1-1 • Disponible en
español en línea o en la oficina local**