**Center Applicant File Review**

**Center Recommendation of Denial Form for Age or Low Income Due to Disability Status**

*(For Center Use)*

*(To be completed by the center’s File Review Coordinator, i.e., Health and Wellness Director or designee)*

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| --- | --- | --- | --- |
| **Applicant Name:** |  | **ID#:** |  |
| **Center:** |  | **Regional Office:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Eligibility Re-evaluation due to Eligibility Requirement Criterion 2 (age) or Eligibility Requirement Criterion 3 (low income) from Exhibit 1-1 related to Disability Status** *(i.e., the applicant is older than age of 24 and/or considered a family of one for low-income consideration because of being a person with a disability).* | | | | | |
|  | A. | Age |  | D. | Low Income |
| Summarize why the center does not believe this applicant to be a person with a disability. | | | | | |
|  | | | | | |

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| --- | --- | --- | --- |
| **Signature *(****of Person Completing the Form***):** |  | **Date:** |  |
| **Title:** |  | | |

*Upload to the Wellness and Accommodation E-Folder (i.e., Health E-Folder under “OTHER.”) and select the Flag for Regional Review within CIS.*