HOMECARE WORKER
Supplemental & Benefit Trusts

Providing Benefits to Oregon Homecare and Personal Support Workers

Eligibility and Reimbursement Appeal Form

Please check the box that best describes the reason for your appeal, submit a letter explaining the circumstances of your appeal, and provide the documentation requested for the appeal type you have chosen. If the above items are not provided, review of your appeal may be delayed. Your appeal will be decided within 30 days of receipt of all the necessary documents.

- ☐ Eligibility Determination for Dental, Vision and Employee Assistance Program benefits. Requires documentation for hours worked during the relevant period.
- ☐ Reimbursement Amount was Paid Incorrectly. Send copies of Reimbursement Form and documentation required from that form.
- ☐ Reimbursement Amount was not received. Resend the Reimbursement Form and all required documentation.
- ☐ Eligibility determination under the Supplemental trust. Requires documentation for hours worked during the relevant time period.
- ☐ Other. Please specify in your letter the circumstances and appeal request and provide supporting documentation.

_____ _____

Participant Signature Date

Legal Name (Last, First, MI): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Best Phone Number to Reach You: _____

Please mail or fax this form and supporting documents to: Oregon Homecare Workers Trust, PO Box 6, Mulkiteo, WA 98275. Fax: 1-866-459-4623.

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