Reemployment Assistance Appeals

OVERVIEW: Claimants who don't agree with their Reemployment Assistance eligibility notice have the option to request an appeal within 20 calendar days after the distributed date of the notice. To access the Notice of Appeal Form click here.

HOW TO VIEW YOUR NOTICE: There are multiple ways for a claimant to view eligible and ineligible notices. These ways include:

- The claimant's CONNECT inbox;
- U.S. mail, if the claimant selected this correspondence method as their preference in their CONNECT account; or
- In the Determination, Pending Issue and Decision Summary section in the claimant's Reemployment Assistance account.

HOW TO FILE AN APPEAL: If a claimant disagrees with any ineligibility notice issued on their Reemployment Assistance claim, they have the right to file an appeal. All requests for an appeal hearing should be filed within 20 calendar days after the distribution date provided on the notice. If the 20th day falls on a Saturday, Sunday, or legal holiday, the appeal may be filed on the next business day. Claimants may submit a request for an appeal by:

- Selecting the issue identification number from their "Determination, Pending Issues, and Decision Summary" screen, located in their Reemployment Assistance account.
- Faxing the following Notice of Appeal form to the Appeals Clerk's Office at 850-617-6504.
- Mailing the Notice of Appeal form to:

  The Florida Department of Economic Opportunity
  Office of Appeals
  PO Box 5250
  Tallahassee, FL 32399

ADDITIONAL INFORMATION: If there are any additional questions about filing an appeal or a pending appeal request, please visit the Reemployment Assistance Help Center at FloridaJobs.org/RAHelpCenter.

OFFICE OF APPEALS
NOTICE OF APPEAL

This form may be used to appeal an adjudication examiner's determination. The preferred method for filing the appeal to your determination is via CONNECT (located through floridajobs.org) or through the Reemployment Assistance Help Center (located at floridajobs.org/rahelpcenter. This form is **not** intended for use in filing an appeal with a District Court of Appeal.

NOTICE TO CLAIMANTS: **You must continue claiming, even if you have been denied benefits**; otherwise, additional benefits may not be paid. **Direct all questions about your claim to (833) 352-7759.**

COMPLETE THE FOLLOWING INFORMATION:

Claimant Name: _____ Telephone: _____
Address: _____
City: _____ State: _____ Zip: _____
Claimant ID: _____
Last four digits of Claimant's Social Security Number: _____

Employer Name (if applicable): _____
Employer Account Number (if known): _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Employer Contact Person: _____ Telephone: _____

REPRESENTATIVE – If you are filing on behalf of a party, provide the following:
Name of Representative: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____ Telephone: _____

APPEAL HEARING STATEMENT AND REQUEST FOR HEARING

I AM APPEALING THE DETERMINATION DATED_____. The issue identification number on the determination is _____. (Attach copy if available.) Appeals must be filed within 20 calendar days of the determination date. If not, state the reason for late filing. If mailed, the date of filing will be based on the postmark date; if faxed, the date the filing will be the date recorded on the document by the Department or Commission fax system; if emailed, the date of filing will be when sent, as recorded in the email; if submitted in CONNECT, the date of filing will be the CONNECT received date; if submitted through the Reemployment Assistance Help Center, the date of filing will be the Help Center received date; and if delivered in person, the date of filing will be the date of hand delivery.

I disagree with the determination because: _____
_____
_____
_____

(if applicable) My appeal is filed late because: _____
_____
_____

I. TRANSLATION

( ) I need an interpreter. Specify language: _____.
Or
( ) I do not need an interpreter.

II. WITNESSES

Do you expect to call witnesses to testify at the hearing? **YES / NO** (circle one)

Will subpoenas be requested for any witness? **YES / NO** (circle one)

III. REPRESENTATION

Will you be representing yourself at the hearing? **YES / NO** (circle one)

If you selected no, list the name and phone number for your authorized representative.

Representative Name	**Phone Number**

IV. EXHIBITS

Do you have any documents or exhibits that you intend to use at the hearing? **YES / NO** (circle one)
If yes, it is your responsibility to submit documents or exhibits in accordance with the instructions, which will be provided on your *Notice of Appeal Hearing*.

Signature: _____Print Name:_____ Date:_____
I am: ( ) the claimant; ( ) the claimant's representative; ( ) the employer; ( ) the employer's representative

MAIL OR FAX THIS FORM TO:

DEO Office of Appeals
PO Box 5250
Tallahassee, FL 32399
Fax: (850) 617-6504

FOR IN PERSON OR COURIER SERVICE SEND TO:

DEO Office of Appeals
MSC 347
107 E. Madison Street
Tallahassee, FL 32399

***PRIVACY ACT STATEMENT**
Information you provide to this department is voluntary and confidential but is required to process your claim. Pursuant to the Internal Revenue Code of 1986, the Social Security Act, 42 U.S.C. 1320b-7(a)1, and s. 443.091(1)(h), F.S., disclosure of your Social Security number is mandatory. Social Security numbers will be used by the department to report the benefits you receive to the Internal Revenue Service as potential taxable income. In accordance with the Federal Deficit Reduction Act, an amendment to the Federal Social Security Act, and 5 U.S.C. 552a(o)(1)(D), information you provide is subject to verification through computer matching programs and information about your wages and claim may be provided to other federal, state and local agencies or their contractors for verification of eligibility under other government programs to ensure benefits have been properly paid and for statistical and research purposes.
An equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities.

Form: Notice of Appeal
Form # DEO – A100(E) (01/23)
Rule 73B-20.003, F.A.C.