

**Request for Waiver of Appeal Fee**

Name: \_\_\_\_\_

Hearing Examiner File: \_\_\_\_\_

SMC 3.02.125 provides that the Hearing Examiner may waive an appeal fee if its assessment “will cause financial hardship to the appellant.” To request a fee waiver, please answer the following questions.

1. What is your current monthly income? \$ \_\_\_\_\_ /mo.
2. What (approximately) was your total income in the last calendar year?  
\$ \_\_\_\_\_
3. How many persons other than yourself do you support, and what are their ages? \_\_\_\_\_
4. What is your monthly rent or mortgage payment? \$ \_\_\_\_\_
5. Please explain why you are requesting a waiver of the appeal fee and provide any information you believe supports your request.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I request a waiver of the appeal fee in the appeal indicated above. I swear or affirm that the information provided above represents a true and accurate estimate of my income and expenses. I further swear or affirm that it would cause me financial hardship to pay the appeal fee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date