Letter of Appeal for Mobility Assistance Services

Date: [Insert Date]

To: [Recipient's Name]
[Recipient's Title]
[Hospital's Name]
[Hospital's Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally appeal for mobility assistance services as part of my discharge plan from [Hospital's Name] on [Discharge Date]. Due to [specific medical condition or reason], I require additional support to ensure a safe and comfortable transition from the hospital to my home.

As outlined in my medical records, my current condition limits my ability to [explain limitations, e.g., walk independently, navigate stairs, etc.], which could lead to [explain potential risks, e.g., falls, injury, etc.] if not adequately supported. Therefore, I kindly request the provision of mobility assistance services, including [specify type of assistance needed, e.g., wheelchair transportation, home health aide, etc.].

I believe that receiving this assistance will significantly enhance my recovery and prevent any complications associated with my condition. I appreciate your consideration of my appeal and look forward to your positive response.

Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]