Manitoba



Health Appeal Panel for Home Care Rm. 4012 - 300 Carlton St.

Winnipeg MB R3B 3M9

Telephone: 788-6788 Fax: 948-2024 Toll Free 1-800-491-4993

Email: appeals@gov.mb.ca

Website: www.homecareappeals.mb.ca

Notice of Appeal

Client Name:		Age:		
		Agc		
Address:				
Postal Code:				
Case Coordinator:				
Local Regional Health Authority Office:				
Reason for Appeal: 1. I applied for Home Care services and disa a) eligibility for service b) level of service 2. I disagree with Home Care Program chang 3. Other:	ges to my care plan	out my:		
Describe specific reason for appeal:				
What I want/expect:				
(use reverse side	of this form if required)			
Have you brought this most recent concern to	the attention of the local RHA	☐ Yes		No
What was the response to your concern?				
I give my consent for the Appeal Panel f Provincial Home Care Program. Date:	or Home Care to obtain my	records f	rom	the
	Client/designate signat	ture		

Please turn over

	Client/designate signature				
If this appeal is being filed by someone of	her than the cli				
Name:	Relationship to client				
Is client aware that you are filing this app reason)	eal on his/her b	oehalf? YesNo_	(if no give		
Address:					
Postal Code:					
Dated at					
	 - 				

Notice of Appeal should be sent to the "Appeal Panel for Home Care" at the above address.