

Notice of Appeal

To be completed by Client

The information you provide on this form is collected under the authority of the Sections 4.1 and 4.2 of the Aids to Daily Living/Extended Health Benefits Regulation 236/85 and will be protected under the provisions of the Freedom of Information and Protection of Privacy Act (FOIP). The information will be used to determine and verify your eligibility for Alberta Aids to Daily Living (AADL) Cost-Share Exemption. If you have any questions about the collection of this information, you may contact the FOIP Coordinator, Alberta Seniors and Community Supports, 2nd floor, Standard Life Centre, 10405 Jasper Avenue, Edmonton, Alberta T5J 4R7, Telephone 415-6039 in Edmonton or toll-free by dialing 310-0000 and entering (780) 415-6039.

1. Status Appealed

Pursuant to the provisions of Sections 4.1 and 4.2 Amendment (O.C.414/87) to Aids to Daily Living/Extended Health Benefits Regulation 236/85, notice is hereby given to the Department of Alberta Seniors and Community Supports, in the Province of Alberta, that I,

_____,
Name (First and Last Name)
_____, _____, _____ of
Birthdate Personal Health Number (PHN) Telephone Number

Street/P.O. Box City/Town/Municipality Alberta Postal code

have been affected by a decision made on cost sharing [Section 3 (e.1)] under the Regulation indicated above, and that I appeal my eligibility to cost-share in respect to AADL benefits.

2. Grounds for Appeal

Your current income was too high to qualify for AADL Cost-Share Exemption. Please explain why you are requesting an exemption for paying a portion of the cost of your AADL benefits (be specific):

3. Income Information

PLEASE PROVIDE THE FOLLOWING INFORMATION AND ATTACH VERIFICATION OF THE PREVIOUS YEAR'S INCOME TAX RETURN: (Available from Canada Revenue Agency)

As shown on line 150 of my (our) _____ Tax Return:

Taxable Income for Applicant \$ _____

Taxable Income for Spouse \$ _____

Family Combined Taxable Income \$ _____

**IF NO INCOME OR NO TAXABLE INCOME,
PLEASE INDICATE HOW YOU ARE BEING
SUPPORTED.**
(Attach verification)

I CERTIFY THAT:

1. The information given by me in the above declaration is true and correct; AND
2. I am not exempt from paying income tax because I belong to or am a member of a religious or charitable society, order or Community.

_____ Applicant's Signature

_____ Social Insurance Number

_____ Spouse's Signature

_____ Social Insurance Number

_____ Date

4. Expenses

Please complete your expenses based on the last 12 month yearly period:

	Description of Benefit	Monthly	Annual
1.	Rent		
2.	Food		
3.	Utilities		
4.	Electricity		
5.	Phone		
6.	Cable		
7.	Transportation		
8.	Home Care		
9.	Health Care Insurance		
10.	Private Health Care Insurance		
11.	Aids to Daily Living (Medical Supplies)		
12.	Pharmacy Bill		
13.	Miscellaneous		
	Total Living Expenses for one Month		
	Total Living Expenses for one Year		
	Net Take Home Pay Per Month		
	Net Take Home Pay Per Year		
	SURPLUS		

Name	Personal Health Number (PHN)
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5. Additional Remarks

6. Benefits in Question

List the AADL benefits (their estimated quantity and cost) that you will require from Alberta Aids to Daily Living during this benefit year (July 1, _____ to June 30, _____).

Do not include the cost of upgrades..

Description of Benefit	Quantity (Estimate)	Cost (Estimate)
1.		
2.		
3.		
4.		

Indicate the estimated total amount you expect to pay, as a result of cost sharing, for these benefits during this benefit year (July 1, _____ to June 30, _____); \$ _____ (not to exceed \$500.00).

7. Signatures

I understand a Department Supervisor or management staff will conduct an informal review (administrative review) of the decision right away to see if the problem can be solved without a formal review (appeal hearing). I understand if the problem is not solved, my appeal will automatically go to the Citizen's Appeal Panel **unless I withdraw my appeal verbally or in writing.**

_____ Date

Client's Signature

_____ Date

Reviewed by - ADDL Representative's Signature

AADL OFFICE USE ONLY

Date of receipt of Appeal form	Date of Administrative Review	Decision of Administrative Review
Date of Appeal Hearing	Date sent to Appeal Panel	Decision of Appeal Panel
Prepared by	Date	