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.

	Sections 4.1 and 4.2 Amendment (O.C.414/87) to otice is hereby given to the Department of Albert	· · · · ·	•
	Name (First and Last Name)		
Birthdate ,	Personal Health Number (PHN)	,Teleph	none Number
		Alberta	
Street/P.O. Box	City/Town/Municipality		Postal code

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 \$ IF NO INCOME OR NO TAXABLE INCOME, Taxable Income for Spouse \$ULASE INDICATE HOW YOU ARE BEING SUPPORTED. Family Combined Taxable Income \$ (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.		10				Personal Health Numl	ber (PHN)
YEAR'S INCOME TAX RETURN: (Available from Canada Revenue Agency) As shown on line 150 of my (our) Tax Return: Taxable Income for Applicant \$	3. I	Income Infor	mation				
Taxable Income for Applicant \$						ON OF THE PREVIO	US
Taxable Income for Spouse \$		As shown on	line 150 of my (our)	Tax Return:			
Taxable Income for Spouse S PLEASE INDICATE HOW YOU ARE BEING SUPPORTED. (Attach Verification) Family Combined Taxable Income (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 Date 4. Expenses Image: Social Insurance Number 1. Rent Date 2. Food Date 3. Utilities Date 4. Electricity Date 5. Phone Date 6. Cable Date 7. Transportation Date 8. Home Care Date 9. Health Care Insurance Date 10. Private Health Care Insurance Date 11. Aids to Daily Living (Medical Supplies) Date 12. Pharmacy Bill Date 13. Miscellaneous Date 14. Electricity Date 15. Phone Date 16. Cable Date <td></td> <td colspan="2">Taxable Income for Applicant</td> <td>\$</td> <td colspan="2" rowspan="2">PLEASE INDICATE HOW YOU ARE BEING</td> <td>IE.</td>		Taxable Income for Applicant		\$	PLEASE INDICATE HOW YOU ARE BEING		IE.
Family Combined Taxable Income \$	Taxable Income f		me for Spouse	¢ P			
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SURPLUS

Name				Perso	nal Health Number (PHN)
5. Additional Remar	ks				
6. Benefits in Questi	on				
List the AADL benefits (their estimated quantity and	d cost) that you will i	require from Alb	perta Aids	s to Daily Living during
	to June 30,	, ,			
Do not include the cos		<i>,</i>			
	Description of Benefit		Quantity (Es	timate)	Cost (Estimate)
1.					
3.					
4.					
Indicate the estimated to	otal amount you expect to p	ay, as a result of co	st sharing, for t	hese ber	nefits during this benefit
	to June 30,); \$	-	exceed \$500.0		Ű
7. Signatures					
I understand a Departmethe decision right away to the problem is not solve	ent Supervisor or managen to see if the problem can be d, my appeal will automatic	e solved without a fo	ormal review (ap	peal hea	aring). I understand if
verbally or in writing.					
Client's Signature			Date		
Reviewed b	y - ADDL Representative's Signat	ure			Date
D · · · · · · · · · · · · · · · · · · ·	1	OFFICE USE C			
Date of receipt of Appeal form	Date of Administrative Review	Decision of Administrat			
Date of Appeal Hearing	Date sent to Appeal Panel	Decision of Appeal Par	nel		
Prepared by			Date		