

Please print.

Application for Review of a Decision

Family benefits and refundable tax credit for child assistance

Use this form to apply for review of a decision regarding family benefits or the refundable tax credit for child assistance.

You have 90 days following the date of the decision to file an application for review.

1. Identification					
Family name		Given name	Social Insurance Number		
Address (number, street, apartment)					
City	Province		Country	Postal code	
Telephone area code		area code			
home		other		extension	
2. Family allowance or child assi					
Explain why you are applying for	a review and	provide any pertinen	nt documents.		
If your application is related to a cha					
is related to a change in your situat					
Revenue Agency, not the Régie. The	ey will inform u	s of any changes that	must be made to your file	e.	
-					
	If you need m	nore space, continue c	on a separate sheet.		

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Social Insurance Number			1	1		ı
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If the application for review is related to an application for a supplement for handicapped children, complete sections 3 and 4. If not, go to **section 5**.

3. Allowance for handicapped children or supplement for handicapped children							
	ain why you are applying for a review and provi ing your child).	de any pertinent documents (e.g. recent reports from the professionals					
Child	's given name and family name	year month day Date of birth					
	ribe your child's difficulties in daily activities, suc ne. Describe, for example:	h as getting dressed, moving about, eating, communicating and personal					
	 help or special supervision needed for carryin accompaniment needed at school, daycare or difficulties in caring for the child at home; indic describe the professional follow-ups, examina behavioural problems at home, school or day problems related to following a specific diet 	when going out cate how often tions and treatments; indicate how often					
	If you need more space, continue on a separate sheet.						
1 A	dditional information						
	4.1 Has the child be seen by his or her attending physician or another physician since the Régie rendered its decision? Yes No If yes, indicate the physician's name and the location:						
	Physician's name	Location (hospital, clinic, CLSC, etc.)					
	4.2 Has the child's medication been changed (new medication, change in dose) since the Régie rendered its decision? Yes No If yes, indicate the name of the new medication and the dose:						
	Medication	Dose (e.g. 10 mg, twice a day)					
		, o o					

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4. A	dditional information (cont.)							
4.3	Has the child begun a new treatment (physical therapy, occupational therapy, speech therapy, psychotherapy, etc.) since the Régie rendered its decision? Yes No If yes, indicate the treatment, the starting date, frequency and location:							
	Treatment	Starting date	Frequency (per month)	Location (hospital, rehabilition centre, clinic, CLSC, etc.)				
4.4	4 Has the child undergone tests since the Régie rendered its decision, or is he or she expected to undergo tests? Yes No If yes, indicate the test, the date or expected date, and the location:							
	Test	Date (or expected date)		Location				
4.5	Has the child been hospitalized since the Régie rendered its decision? Yes No If yes, indicate the reason, the date and the hospital:							
	Reason	Date	Date Hospital					
5. S	5. Signature							

Social Insurance Number

year

Date

month

day

Signature _____

The form must be signed by the mother, father or person mainly responsible for the child.

Return to:

Régie des rentes du Québec, Service de la révision, C. P. 5200, Québec (Québec) G1K 7S9

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