

To be completed by Client

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):

Name	Personal health number (PHN)
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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 260 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 (yyyy/mm/dd)

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 / Child 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, I can make a written request to the AADL program to forward my Notice of Appeal to the Citizen's Appeal Panel for a hearing.

Client's Signature

Date (yyyy/mm/dd)

Reviewed by - AADL Representative's Signature

Date (yyyy/mm/dd)

AADL OFFICE USE ONLY

Client's application for Cost-Share exemption previously denied <input type="checkbox"/> Yes <input type="checkbox"/> No		Income verified by Canada Revenue Agency (line 260) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eligible for temporary Cost-Share exemption <input type="checkbox"/> Yes <input type="checkbox"/> No		Confirmation of AADL benefits required with mainframe Actual Client Portion _____ Actual AADL Portion _____	
Date of receipt of Appeal form (yyyy/mm/dd)	Date of Administrative Review (yyyy/mm/dd)	Decision of Administrative Review	
Date of Appeal Hearing (yyyy/mm/dd)	Date sent to Appeal Panel (yyyy/mm/dd)	Decision of Appeal Panel	
Prepared by			Date (yyyy/mm/dd)