DEPARTMENT OF SOCIAL DEVELOPMENT AND SENIORS
SOCIAL PROGRAMS **APPLICANT DECLARATION**

APPLICANT APPEAL APPLICATION

APPLICANT INFORMATION:	
Applicant Name:	Provincial Health No.:
Co-Applicant Name:	Provincial Health No.:
Address:	Postal Code:
Email Address:	Telephone:

MAIL APPLICATION OR DELIVER TO:	**OR**	**EMAIL TO:**
Chairperson, Social Programs Appeal Board c/o Administrative Assistant Jones Building 2nd Floor 11 Kent St PO Box 2000 Charlottetown PE C1A 7N8		Pam Sellick pamsellick@ihis.org

Please write or print clearly your reason(s) for requesting an appeal. If more space is required, use the back of this form or another paper source. Notice of intent to appeal must be made within 30 days of the date of the decision having been communicated to you.

Dear Chairperson:

(Please attach additional pages if necessary.)

Date

Applicant Signature

Personal information on this form is collected under Section 31 (c) of the *Freedom of Information and Protection of Privacy Act* and the *Provincial Health Number Act* and will be used for administering the *Social Assistance Act* and the *Rehabilitation of Disabled Persons Act*. If you have any questions about this collection of personal information, you may contact the Manager of Administration, Social Programs, Department of Social Development and Seniors, (902) 368-5230.