



Manitoba Health Appeal Board

102 – 500 Portage Avenue, Winnipeg MB R3C 3X1

T 204-945-5408 Toll Free 1-866-744-3257 F 204-948-2024

Website www.manitoba.ca/health/appealboard

NOTICE OF APPEAL (FOR HOME CARE DECISIONS)

APPELLANT'S IDENTIFYING INFORMATION:

Appellant's Name: _____

Personal Health Information Number (PHIN): _____

Address: _____

Postal Code: _____ Telephone: _____ Email: _____

Case Coordinator: _____

Local Regional Health Authority Office: _____

Preferred pronoun/s (optional): _____

APPELLANT'S REPRESENTATION ON APPEAL:

I will be representing myself on this appeal.

I will be represented by legal counsel:

Name Address Postal Code

I will be represented by another individual*:

Name and relationship to appellant

Street Address City Postal Code

Telephone # Email

***Note:** Please see information set out at bottom of page two regarding the Appellant's representative.

REASON FOR APPEAL:

I applied for or I am receiving home care services and disagree with program decisions about:

a) eligibility for service

b) type of service

c) level of service

1. Describe specific reason for appeal: _____

PLEASE PROVIDE A COPY OF THE WRITTEN DECISION FROM THE REGIONAL HEALTH AUTHORITY WITH THIS NOTICE OF APPEAL.

2. Have you brought this concern to the attention of the local RHA office?

Yes No

3. When you contacted the RHA what was their response to your concern?

4. What I want/expect: _____

Date

Appellant signature*

***PLEASE TAKE NOTICE:**

If this form is not signed by the Appellant or in the case of a minor child, the parent or legal guardian), the person signing on behalf of the Appellant must provide a copy of their authority to do so. For example, an order of committeeship or substitute decision-maker, a grant of power-of-attorney that sets out sufficient authority for the person to act in these circumstances or a representative authorization form, which is available at the board’s office or on its website (see contact information at top of page one).