



Name of Person Appealing:	
Phone Number:	E-mail Address:
I am appealing a decision made by: <i>(select the program that made the decision you are appealing)</i> <input type="checkbox"/> Assured Income for the Severely Handicapped <input type="checkbox"/> Income Supports and Training <input type="checkbox"/> Child Care Licensing <input type="checkbox"/> Family Support for Children with Disabilities <input type="checkbox"/> Child, Youth and Family Enhancement <input type="checkbox"/> Persons with Developmental Disabilities <input type="checkbox"/> Other (specify program) _____	
I appealed this decision on _____ <i>date you appealed</i>	

My signature below indicates that I agree to the following (strike out and initial any provision you do not wish to authorize):

1. I authorize the Appeals Secretariat to disclose information to the individual(s) named and listed below as it relates to my appeal.
2. This authorization allows the individual(s) named and listed below to provide any information to the Appeals Secretariat as it relates to my appeal.
3. This authorization allows the individual(s) listed below to represent me at my appeal hearing.
4. I understand I must notify the Appeals Secretariat immediately if I choose to no longer allow the person named and listed below to act on my behalf.
5. I understand that providing this authorization does not preclude me from participating fully in my appeal process and hearing.

I authorize the following individual(s):
Authorized individual's/individuals' telephone number and e-mail:

Please sign and date below

Signature of Person Appealing:	Date:
Signature of Witness:	Date:
Printed Name of Witness:	

Please note, the witness cannot be the individual being authorized to represent the Appellant and must be someone over the age of 18.

Return completed forms by Mail: Appeals Secretariat 2nd Floor, Agronomy Centre 6903 116 Street NW Edmonton, AB T6H 5Z2	Return completed forms by E-mail: css.appeals@gov.ab.ca Return completed forms by Fax: (780) 422-1088
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