Ontario Works Program
Housing and Social Services Department

Request for Internal Review

Name: Member ID:

Date of Birth (mm/dd/yyyy) : Phone Number:

Address:

Case Manager Name: Case Manager Number:

Why do you want to appeal? (Check one box only)

☐ I was refused benefits ☐ My benefits have been reduced

☐ My benefits have been cancelled ☐ I was charged with an overpayment

When was this decision made? Enter a date:

Why do you disagree with the decision made? Provide details below:

Declaration and Consent - I declare that the information given above is correct and complete.

Signature:_____ **Date:** _____

Please note: You must send this form to Ontario Works within thirty (30) days of receipt of the decision you are appealing. If you are sending the request beyond the thirty days, please explain the reason you were unable to request the internal review within the set time period. To avoid delays, make sure the information you provide is complete. Please notify us of any change to your address.

Notice with Respect to the Collection of Personal Information

(Freedom of Information and Protection of Privacy Act)

(Municipal Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Works Act,* 1997, section 7, 8, 57 & 58 of the *Ontario Disability Support Program Act,* 1997, sections 5, 10, 45 & 46 for the purposes of administering Government of Ontario social assistance programs.

Please complete form in full, sign and deliver to:
Ontario Works, 362 Montreal Street, Kingston, ON K7K 3H5

Inquiries can be directed to:
Phone: 613-546-2695