



REQUEST FOR ADMINISTRATIVE REVIEW FOR PWD AND MNS CLIENTS

Protected **B** (when completed)

Privacy Statement: The personal information collected on, and disclosed pursuant to, this document is collected pursuant to the Indigenous Services Canada (ISC) Social Development Policy and Procedures Manual, Vol. 1, BC Region for the purpose of determining eligibility for assistance and will be maintained pursuant to the Privacy Act and described in the personal information bank INA-PPU-240. The accuracy of the information in this document may be checked by comparing it against information held by any federal or provincial department or agency or any private agency.

* Please complete in full * Please print clearly			T =	
	Administerin	g Authority Name	Administering	g Authority Number
SECTION A - Decision to be reviewed (to be completed by the Band Social Development Worker)				
Applicant's Name:		Date that the Applicant was notified of the decision (YYYY MMM DD):		
A Persons with Disabilities (PWD) Designation Applicant and/or Monthly Nutritional Supplement (MNS) Applicant may request an administrative review of the following decisions (please indicate the applicable application and reason for the review):				
PWD Designation Application		MNS Application		
☐ Refusal to grant an allowance or service		☐ Refusal to grant an allowance or service		
☐ Cancelation of an allowance or service		☐ Cancelation of an allowance or service		
☐ Suspension of an allowance or service		☐ Suspension of an allowance or service		
☐ Reduction of an allowance or service		☐ Reduction of an allowance or service		
Statement of Decision (including the relevant section of policy quoting the reason(s) for the decision):				
BSDW Name (Please print)		Signature of BSDW		Date signed (YYYY MMM DD)
SECTION B - Request for an Administrat	ive Review ar	nd the reasons for the	request (to be	completed by the Applicant)
SECTION B - Request for an Administrative Review and the reasons for the request (to be completed by the Applicant) Important: You must complete this section and submit the completed form to your BSDW within 20 business days from the				
date of notification of the decision if you wish to request for an Administrative Review. You may also attach new information and documents that you wish to have considered with this request.				
I am dissatisfied with the above decision and wish to request an Administrative Review of the decision for the				
following reasons:				
I have attached new documents I wish to have considered		d (please check one):	Yes	No
Signature of Applicant		Date signed (YYYY MMM DD)		
Mailing Address		Postal Code	Telephone Number	
Band Social Development Worker (BSDW): Please fax this request to the British Columbia Aboriginal Network for Disability Society (BCANDS) at 250-381-7343 or by email to pwd@bcands.bc.ca The review shall be conducted within 20 days of request.				