

This is an Appeal Application Form. If you have applied for a HSE payment or service and you are not happy with the decision, you can use this form to make an appeal.

If you would like help to fill out this form, please ask any of our staff.

Your appeal should be sent to us within 3 weeks of receiving your written decision.

Please write in BLOCK LETTERS.

The Appeals Office may need to check some of the information you have given us and may use the Department of Social and Family Affairs database. We will treat all the information you give us as confidential and will only share your information if we are required under the law. Your information is protected by the Data Protection Act and the Freedom of Information Act www.oic.gov.ie

The Appeals Office will save some of the information you give us on computer.

When you sign this form, you give the Appeals Office your permission to make any enquiries needed in order to process your appeal.

When you have filled out this form, send it to:

Please leave this space blank for office use

Details

1. Name	3. Date of Birth Day Month Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. Address	4. PPS Number Numbers Letters <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	5. Phone Number <input type="text"/>
	6. Email Address <input type="text"/>
	7. Medical Card No <input type="text"/>

Your Husband/Wife/Partner's Details

8. Name	10. Date of Birth Day Month Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
9. Address	11. PPS Number Numbers Letters <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	12. Phone Number <input type="text"/>
	13. Email Address <input type="text"/>
	14. Medical Card No. <input type="text"/>

15. Details of your Dependants

Name	Date of Birth	Relationship to You	Weekly Income
A.			€
B.			€
C.			€
D.			€
E.			€

What Payment/Service did you apply for

16. A. Supplementary Welfare Allowance* E. Motorised Transport Grant
 B. Medical Card F. Supplementary Blind Welfare Allowance
 C. Nursing Home Subvention G. Domiciliary Care Allowance
 D. Enhanced Subvention H. Mobility Allowance
 Other (Please give details)

* This is a payment made by your Community Welfare Officer.
 For Example: Basic Weekly Allowance, Rent Supplement, Diet Supplement, Heat Supplement, Travel Supplement, Payment for Exceptional Needs etc.

17. When did you apply?

18. What office did you apply to?

19. Who did you deal with (if you know)?

20. Did you make the application for another person? Yes No

21. If 'Yes', please give their name and address

Name	Address

What is their relationship to you

22. Did you get a letter telling you about the decision made on your application Yes No

Are you making this appeal because

23. You have unusual expenses, such as medical bills, loans etc that you did not include in your application?	Yes	No
24. Your family income has changed?	Yes	No
25. Your family situation changed (for example, new baby etc)	Yes	No
26. Other reason?		

Income Details

**If you are appealing for Domiciliary Care Allowance -
Please give details of child's income only (awards/compensation) in the section below.**

27. Amount of your income per week	€
28. Source of your income eg wages, social welfare	
29. How long have you received this income	
30. Do you or your Husband/Wife/Partner have any other income?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
31. If 'Yes' state amount per week	€
32. Source of other Income	

33. Income of your Husband/Wife/Partner	€
34. Source of his/her income eg wages, social welfare	
35. How long has he/she been in receipt of this income?	

36. If there is anyone else living with you, please give details				
Name	Date of birth	Relationship to you	Weekly Income	Where does this Income come from
A.				
B.				
C.				
D.				
E.				

English Appeal Form

Outgoings

37. Please state amount of rent/mortgage per week € . Per month € .

38. Please give details of other loans/debts/exceptional outgoings

€	Per week/month	To whom
A.		
B.		
C.		

Please send us any documents you think will help your appeal. For example: payslips, medical reports, receipts etc.

39. Please tell us about your reasons for making the appeal:

40. If necessary would you like to speak to an Appeals Officer about your appeal Yes No

41. The information I have given is true to the best of my knowledge

Signed:

Dated: