City of Kingston
Ontario Works Program
Community and Family
Services Department

362 Montreal Street
Kingston, Ontario
Canada K7K 3H5

Telephone: (613) 546-2695
Fax: (613) 546-9658

ONTARIO WORKS PROGRAMS

REQUEST FOR INTERNAL REVIEW

NAME: ______________________________ **MEMBER ID:** ___________________________

D.O.B.: ______________________________ **PHONE #:** ______________________________

ADDRESS: ____

____

CASE MANAGER NAME: ____ **C.M. #:** _______

WHY DO YOU WANT AN 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? ____

Why do you disagree with the decision made? ____

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Please note: You must send this form to Ontario Works <u>within thirty (30) days</u> 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.

Signature: __________________________________ **Date:** _____________________________