Request for Internal Review Form

Please type or print and submit to:
The Regional Municipality of York, Housing Access Unit, 55 Eagle Street West, Newmarket

Last Name:	First Name:	
Mailing Address:	Apt. #	
City:	Province:	Postal Code:
Telephone number where you can be reached:	Area Code: ( ) Number:	

1. What is the date on your Notice of Decision? Month: Day: Year:

2. Why do you want to appeal? (Please check one box)

- ☐ Do not agree with the decision that we are not eligible for assistance
- ☐ Do not agree with the decision of the bedroom size for our household
- ☐ Do not agree with the decision that we are not eligible for Special Priority Status.
- ☐ Other _____

3. Why do you disagree with the decision made? Please write the reasons below and attach supporting documentation. (If you require additional space, please use the space provided on the back.)

_____

_____

_____

Please Note: You must sign and deliver this form by fax, mail or in person within 10 business days of receipt of the Notice of Decision you are appealing. To avoid delays, make sure that the information you give is complete.

Send to: The Regional Municipality of York
55 Eagle Street West
Newmarket ON L3Y 8W5

Fax: (905) 830-5023

Contact: Supervisor Housing Access Unit
Telephone: (905) 830-4444 Extension 2470
Toll free: 1-877-464-9675

Office hours: Monday to Friday 8:30 a.m. to 4:30 p.m.

Applicant(s) Signature: **Please Note:** You must be 16 years of age or older to request an Internal Review	Date Month: Day: Year:

For Office Use Only

Date Received: _____

Date Forwarded for IR: _____

Date IR Decision Received: _____

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3. Continued — Why do you disagree with the decision made? Please attach supporting documentation.