DISABILITY LIVING ALLOWANCE AND AA ENTITLEMENT APPEAL LETTER

NAME:
Name of Appointee:
ADDRESS:

Date of Birth:
National Insurance No:

APPEALS SEND TO:
HMCTS SSCS Appeals Centre
PO Box 27080
GLASGOW
G2 9HQ

Dear Sir or Madam

Please accept this as an appeal against my entitlement to **Disability Living Allowance (DLA) or Attendance Allowance** (*please delete) on **Date of Decision:** _____

The Grounds of Appeal - The decision you have reached does not accurately reflect my care and supervision needs and/or the restrictions on my mobility. In addition it is submitted that the decision-maker has not followed the correct test for entitlement as stated by the Upper Tribunal and higher Courts and that I should be entitled to: (* please tick)

☐ Disability Living Allowance Care Component

☐ Attendance Allowance

☐ Disability Living Allowance Mobility Component

☐ **I have enclosed my mandatory reconsideration notice**

SPECIAL REASONS FOR LATE APPEAL (see over)

My representatives are **Welfare Rights Section, Glasgow City Health and Social Care Partnership, City Chambers East, 40 John Street, Glasgow, G1 1JL**. I authorise them to act on my behalf. Please ensure they receive copies of all further correspondence and a copy of the appeal papers.

I do not consent to my appeal being heard without an oral hearing. I do not consent to less than the full advance notice stated in rule 29(2) of the Tribunal Procedure Rules 2008. Should you decide to schedule my appeal in a manner contrary to these instructions then please contact my representatives to ensure that my right to a fair hearing under Article 6 of the ECHR remains protected.

Yours faithfully

I require an interpreter in: Language: _____ Dialect: _____

Signature: _____ Date: _____