LOUISIANA DSS Department of Social Services	**Agency Name**	Office of Family Support (OFS)			
	Chapter No./Name	00. Miscellaneous Issuances Manual			
	Part No./Name	E. Executive Bulletins			
	Section No./Name	E-2300 Executive Bulletins			
	Document No./Name	E-2328-01 Louisiana Combined Application Project (LaCAP)			
	Dates	**Issue**	June 20, 2007	**Effective**	June 20, 2007

The Louisiana Combined Application Project (LaCAP) is a Food Stamp Program demonstration project that the Food and Nutrition Service (FNS) approved for a six-year period. As a condition of this approval, Louisiana is required to determine the impact on benefit levels of LaCAP recipients.

Effective June 18, 2007, the Program Policy Section will mail a LaCAP survey to a small portion of currently certified LaCAP recipients each month. Recipients will be asked to complete the survey and return it to the Program Policy Section within ten days of the mailing date. A self-addressed stamped return envelope will be enclosed so that the completed survey can be easily returned to the Program Policy Section. A copy of the LaCAP survey is attached.

When the completed surveys are received, Program Policy Section staff will determine the allotment these individuals would be receiving if they were enrolled in the regular Food Stamp Program rather than LaCAP. If the completed survey indicates that the LaCAP recipient is not eligible for LaCAP benefits, the appropriate parish office will be notified. In such cases, the local office will send an advance notice of adverse action (LaCAP 4, Action Taken on Your LaCAP Case) advising the recipient of ineligibility for LaCAP and encouraging them to apply for the regular Food Stamp Program. If the completed survey indicates the LaCAP recipient is still eligible for LaCAP benefits, the benefit level will remain unchanged and the parish office will not be contacted.

If a LaCAP recipient contacts the parish office with questions about the survey that the parish office staff cannot answer, refer the LaCAP recipient to the Program Policy Section at 225-219-0351.

Contact the appropriate Regional FS/CCAP Program Specialist if you have any questions.

Attachment

Louisiana Department of Social Services
Office of Family Support
Program Policy Section
627 North 4th Street, Fl-5
Baton Rouge, LA 70802

Louisiana Combined Application Project Survey

Date:_____

Case ID:_____

Parish:_____

You currently receive food assistance through the Louisiana Combined Application Project (LaCAP). Louisiana is required to complete a survey of LaCAP recipients to compare their LaCAP benefits to what they would receive through the regular Food Stamp Program. Please answer the questions below and return to the Office of Family Support Program Policy Section in the enclosed envelope by _____. If you need help completing this form or have any questions, please call 225-219-0351.

1. Phone number where you can be reached during the day: _____
2. E-mail address, if available: _____
3. Do you live alone? ☐ Yes ☐ No
4. **If no**, do you buy and prepare meals separately from others in your home? ☐ Yes ☐ No
5. Do you live with your spouse? ☐ Yes ☐ No
6. Do you live with your child who is under 22 years of age? ☐ Yes ☐ No

Tell us about any money you receive for work including full-time, part-time, temporary, or seasonal jobs, self-employment, training, or military reserve pay. This includes money received from wages, salaries, tips or commissions.

7. Do you work? ☐ Yes ☐ No
8. If you work for an employer, complete the following. Use plain paper if you need more space.

Employer's Name: _____ Employer's Phone Number: _____

Employer's Address: _____

How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly ☐ Other _____

Number of hours worked per week: _____ Hourly wage: _____

Number of days worked per week: _____

Do you ever work overtime? ☐ Yes ☐ No

If yes, how often? _____ How many hours? _____

Are tips earned? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

9. Complete the following information if you are self-employed. *This includes fishermen, child care providers, hair dressers, and people who do odd jobs such as cutting grass, picking up cans, etc. Use plain paper if you need more space.*

Type of Business/Work: _____

Monthly Business Income: _____

Monthly Business Expenses: _____

Number Hours Worked Per Week: _____

10. If you are receiving money from a source other than work, check each type of income.

- ☐ Annuity income
- ☐ Contributions
- ☐ Disability insurance benefits
- ☐ Energy check
- ☐ Gifts
- ☐ Interest income
- ☐ Loans
- ☐ Military allotment
- ☐ Oil lease/Royalties
- ☐ Railroad benefits
- ☐ Rental Income
- ☐ Retirement/Pension
- ☐ Roomer/Boarder
- ☐ Social Security
- ☐ SSI
- ☐ Spousal support/alimony
- ☐ Tribal money
- ☐ Training Allowance (WIA)
- ☐ Trust Income
- ☐ Unemployment Benefits
- ☐ Veterans
- ☐ Workers Compensation
- ☐ Other

For each box checked above, complete the following information.

Type Of Income	Amount	How Often Received (Weekly, Monthly, Etc.)

11. Check each type of housing expense that you have.

- ☐ Rent
- ☐ Mortgage (if buying)
- ☐ Lot Rent
- ☐ Homeowners Insurance
- ☐ Flood Insurance
- ☐ Gas
- ☐ Property Tax
- ☐ Condominium Fees
- ☐ Electricity
- ☐ Sewer
- ☐ Water
- ☐ Garbage
- ☐ Telephone
- ☐ Other

For each box checked above, complete the following information.

Type Of Housing Expense	Name Of Person Or Company Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

12. Do you pay utility costs for heating and/or air conditioning? ☐ Yes ☐ No
13. Does anyone help you pay your housing expenses? ☐ Yes ☐ No
14. Do you pay court-ordered child support? ☐ Yes ☐ No

If yes, complete the following:

Paid To Whom	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

15. Do you pay medical expenses? ☐ Yes ☐ No

16. Check each medical expense other than medical transportation that you have.

- ☐ Dental Bills
- ☐ Doctor Bills
- ☐ Hospital Bills
- ☐ Health Insurance or Medicare Premiums
- ☐ Medical Appliances
- ☐ Prescribed Medicine
- ☐ Prescription Drug Plan Premium
- ☐ Nursing Home
- ☐ Over the Counter Medicine Prescribed by Dr.
- ☐ Other

For each box checked above, complete the following information.

Type Of Expense	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

Medical Transportation Expense is money spent for trips to the doctor, hospital, drug store, etc., including miles driven in your own vehicle.

17. Do you have medical transportation expenses? ☐ Yes ☐ No

18. Do you use your own vehicle? ☐ Yes ☐ No

If yes, complete the following:

List All Places Visited For Medical Purposes (Ex. Doctors, Drug Store, Hospital, Etc.)	Number Of Miles Traveled Round Trip	Number Of Visits Per Month

19. Do you pay someone else for medical transportation? ☐ Yes ☐ No

If yes, complete the following:

Who Is Paid?	Where Do You Go?	How Much Do You Pay Per Trip?	How Many Trips Do You Pay For Each Month?

Use plain paper if you need more space.

20. Will you be reimbursed for any of the medical expenses listed in questions 15-19? ☐ Yes ☐ No

21. Does anyone help pay the medical expenses? ☐ Yes ☐ No

Thank you for taking the time to complete this survey. If we have any questions, we will call you at the phone number you listed on the first page.

Your Signature (or mark) _____ Date Signed _____