

**Louisiana Department of Children and Family Services**

---

---

---

**Out-of-State Inquiry**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

The person(s) listed below has applied for/is receiving assistance in Louisiana. Since they may have received/currently receiving benefits from your state, we are requesting help in determining his/her eligibility for assistance. Please complete the information requested below and return it to the address above by fax or email as soon as possible. Thank you for your cooperation.

Sincerely,

\_\_\_\_\_  
Agency Representative

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Fax Number

**Case Name:** \_\_\_\_\_

**Case ID Number:** \_\_\_\_\_

**Persons included in the case:**

Name	Date of Birth	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**To Be Completed By Out-Of-State Agency**

1. Did the above-named person(s) receive assistance from your agency? ☐ Yes ☐ No

If **yes**, please answer the rest of the questions below before returning this form.

If **no**, please sign and date this form and return it to our office.

2. Did the person(s) receive TANF benefits from your agency? ☐ Yes ☐ No

☐ Currently receiving If currently receiving, enter amount of monthly benefit: \_\_\_\_\_

Please note any breaks in benefits.

Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

3. TANF, is there a current Child Support Order? ☐ Yes ☐ No If **yes**, please supply the following.

The amount/frequency of ordered support: \$ \_\_\_\_\_.

List obligated parent and name(s) of children:

_____	_____
Parent's name	Children's name
_____	_____
Parent's name	Children's name

4. Other type(s) of financial assistance: \_\_\_\_\_.

5. Was the above-named person(s) certified for SNAP benefits? ☐ Yes ☐ No

☐ Currently receiving If currently receiving, enter amount of monthly benefit: \_\_\_\_\_

Please note any breaks in benefits.

Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

6. Have SNAP benefits been accessed? ☐ Yes ☐ No

Last date accessed: \_\_\_\_\_ Current balance: \_\_\_\_\_

**If possible, please attach the EBT history for this client showing that these benefits were accessed.**

7. Please list the head of Household or Case Name if different from the name listed: \_\_\_\_\_

8. Please list any Income and resources reported in your state (amount and source): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

9. Any additional information that you would like to note: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name (print & sign) Date

\_\_\_\_\_  
Title Telephone Number Email Address