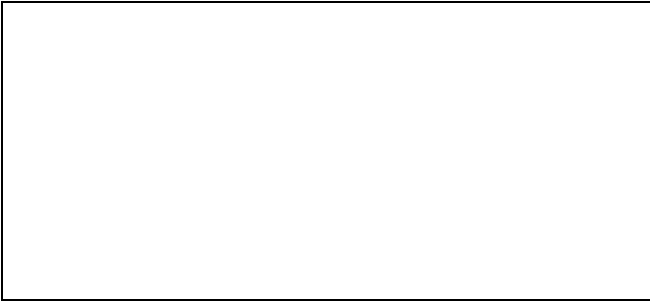


Louisiana Department of Children and Family Services

Simplified Reporting Notice of Incomplete Filing



ID No: _____

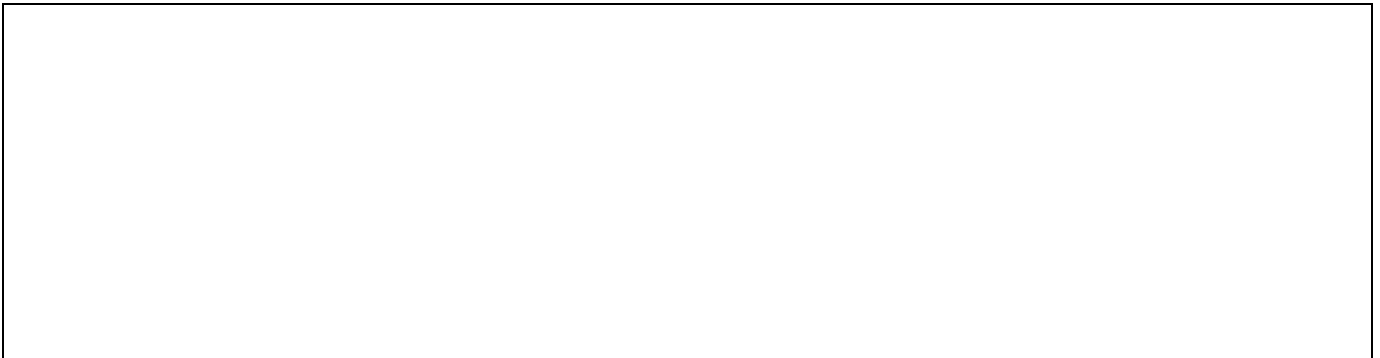
Date: _____

Caseload No: _____

Notice Expiration Date: _____

Your Simplified Report was received but was not complete for the reasons indicated below:

- ☐ Your Simplified Report form was not signed. Please sign the attached form and return it in the enclosed envelope by _____.
- ☐ Your Simplified Report did not contain the following information or required verifications that are necessary to determine your Supplemental Nutrition Assistance Program (SNAP) eligibility and/or benefit amount. Please return the required information to your worker by _____.



-
- ☐ Failure to provide this required information by the Notice Expiration Date listed above will result in the closure of your SNAP case and your FITAP and KCSP cases effective _____.

- ☐ Failure to provide this information by the Notice Expiration Date listed above may result in a decrease in the amount of your SNAP benefits effective _____.

If your SNAP case and your associated FITAP and/or KCSP cases are closed for failure to provide a complete Simplified Report and all required verification and you provide a complete Simplified Report and all required verification after _____ but by _____; your cases may be reopened. Within 30 days of receipt, your worker will determine your eligibility. If you are determined eligible, benefits will be prorated back to the date the complete Simplified Report and all required verification were received. You will have to reapply if the complete Simplified Report and all required verification are not received by _____.

For more information about programs and services or for specific information about your case, call 1-888-LAHELPU (1-888-524-3578).

Agency Representative

Phone No.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the [USDA Program Discrimination Complaint Form](#), found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any

USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State Information/Hotline Numbers](#) (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

USDA and HHS are equal opportunity providers and employers.

Fair Hearing Information

If you think the action is unfair or you do not understand this decision, you or your authorized representative may discuss it with a supervisor in this office. You may also request a fair hearing. If you have not requested a fair hearing by 4:30 p.m. on the expiration date shown above, the change will be made.

If you want to request a fair hearing on a SNAP or money change, complete the section below, sign and mail it or contact me at the local office. You can request a fair hearing on a SNAP change within 90 days of the date of this notice. You can request a fair hearing on a money

change within 30 days of the date of this notice.

If you are currently receiving benefits and you request a fair hearing by the expiration date, you will continue to receive benefits at the current level until the end of your current certification period or until the resolution of the appeal, whichever is earlier, unless you indicate you do not want to do so by checking one of the blocks below. You can represent yourself at the hearing or authorize someone else, such as legal counsel, relative, friend or other spokesman to represent you.

For free legal advice call _____. At the hearing, the Hearing Officer will establish the principal issue. If the sole issue involves disagreement with State or Federal laws or the Agency's policy, the proposed action will be taken immediately. A final decision will be rendered after a careful study is made of the evidence presented.

Complete And Sign Only If You Wish to Request a Fair Hearing

Complete this section and sign below if you wish to appeal the decision on your case. Use the space below to tell why you want a hearing.

- ☐ I am requesting a fair hearing for the benefit checked below within 13 days of the mailing date of this notice and want to continue receiving the amount of benefits I now receive until the fair hearing.

INELIGIBLE ASSISTANCE WILL BE SUBJECT TO REPAYMENT.

- ☐ Money Payment ☐ SNAP benefits

☐ I am requesting a fair hearing for the benefit checked below within 13 days of the mailing date of this notice and do not want to continue receiving the amount of benefits I now receive until the fair hearing.

☐ Money Payment ☐ SNAP benefits

☐ I am requesting a fair hearing for the benefit checked below. Since it is not within 13 days of the mailing date of this notice, I cannot continue receiving the amount of benefits I now receive until the fair hearing.

☐ Money Payment ☐ SNAP benefits

If the final decision is in your favor, retroactive benefits will be issued, if appropriate.

Signature

Date

Phone Number

Return to:

Parish DCFS

