

Action Taken on Your LaCAP Case

ID No.: _____

Date: _____

Notice Expiration Date: _____

Advance Notice of Adverse Action Yes No

Action or proposed action on your LaCAP case is checked below and explained in the "Reason" section.

1. Beginning _____ you will receive \$ _____ per month in LaCAP benefits for the reason listed below.

2. Your LaCAP case will be closed beginning _____ for the reasons listed below.

Reason:

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

Agency Representative

Telephone Number

See other side for important information

Fair Hearing Information

If you think the action is unfair, you or your authorized representative may discuss it with a supervisor in this office and/or request a fair hearing. If this is an Advance Notice of Adverse Action and you have not requested a fair hearing by 4:30 p.m. on the expiration date shown on the front of this form, the change will be made.

If you do not understand this decision, contact your local Louisiana Department of Health. If you want to request a fair hearing on a LaCAP change, complete the section below, sign, and mail it or contact me at the local office. You can request a fair hearing on a LaCAP change within 90 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 only 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. If the final decision is in your favor, retroactive benefits will be issued, if appropriate. If the decision of the local office is upheld, all ineligible assistance will be subject to repayment.

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 within 13 days of the mailing date of this notice and want to continue receiving the amount of LaCAP benefits I now receive until the fair hearing. Ineligible assistance will be subject to repayment.
- I do not want to continue receiving the amount of LaCAP benefits I now receive until the fair hearing. If the final decision is in my favor, retroactive benefits will be issued, if appropriate.

Signature

Date

Telephone Number

Return to: