

# APPOINTMENT NOTICE

DSS-8189 (REV. 12/99)

Date \_\_\_\_\_

COUNTY CASE NUMBER \_\_\_\_\_

CASE I.D. \_\_\_\_\_

DISTRICT NUMBER \_\_\_\_\_

AID PROGRAM CATEGORY \_\_\_\_\_

It is time to review your situation for continued eligibility for:

WORK FIRST FAMILY ASSISTANCE     MEDICAID     FOOD STAMPS

Please meet with me at \_\_\_\_\_

on \_\_\_\_\_ at \_\_\_\_\_

You will need to bring with you the items checked below:

- |   |                                       |  |
|---|---------------------------------------|--|
| ___ Proof of Wages, Earnings  | ___ Bank Statements                   | ___ Life Insurance Policies              |
| ___ Proof of Social Security, SSI,<br>VA Income   | ___ Unpaid Medical Bills              | ___ Birth Certificate                    |
| ___ Proof of all other money you<br>receive   | ___ Health Insurance/Medicare<br>Card | ___ Social Security Card                 |
| ___ Proof of Rent/House Payment   | ___ Proof of Utility Bills            | ___ Proof of Property<br>Taxes/Insurance |
| ___ Proof of immunizations for _____  |                                       |  |
| ___ Name, address, and phone number if available of a person not related to you who is aware of your situation. |                                       |  |
| ___ Other: _____  |                                       |  |
| _____   |                                       |  |
| _____   |                                       |  |
| _____   |                                       |  |

**If you cannot keep this appointment, please call immediately to arrange another time.**

**IF YOU DO NOT COMPLETE YOUR WORK FIRST FAMILY ASSISTANCE REVIEW, YOUR WORK FIRST AND MEDICAID WILL TERMINATE. MEDICAID MAY CONTINUE FOR YOUR CHILDREN. YOU CAN REAPPLY FOR WORK FIRST AND MEDICAID, HOWEVER, YOU WILL NOT BE ABLE TO GET A WORK FIRST CHECK FOR AT LEAST ONE MONTH.**

Caseworker \_\_\_\_\_

DEPARTMENT OF SOCIAL SERVICES

CC: County DSS Record

Phone Number \_\_\_\_\_