LATE/INCOMPLETE NOTICE

	CASE IDENTIFICATION							
со	RECORD NUMBER	BU GP	CD	FS-SUFF	FSCD	DIST	CSLD	

REPORTING FOR	

Si necesita este formulario en español comuníquese con trabajador a social que maneja su caso inmediatamente. Usted debe completar, firmar y devolver este formulario a la Oficina de Asistencia del Condado en la fecha indicada o con anterioridad a ella, de lo contrario su caso será cerrado, incluyendo su asistencia medica y/o sus cupones de comida. (55 PA CODE 142.23(g), 7 CFR 273.12(a)(1)(vii). 55 PA Code 133.84(d).

THIS ADDRESS MUST APPEAR IN THE WINDOW OF THE ENCLOSED ENVELOPE WHEN RETURNING THIS FORM.
THIS FORM.

IMPORTANT

YOUR SEMIANNUAL REPORTING FORM FOR THE MONTH SHOWN ABOVE WAS:	\	NOT RECEIVED BY DUE DATE	NOT SIGN	NED INCOMPLETE
BECAUSE OF THIS YOU MAY NOT RECEIVE YOUR CASH OR FOOD STAMP BENEFITS OF:	A		ON TIME	55 PA CODE 133.84(d), 142.23(h), 7CFR 273.12(a) (1)(vii)

IMPORTANT

If this form is received in the county assistance office before or on and all information is complete and you remain eligible, your cash, food stamps or child care payment will be received on time. If the form is received after the date shown and you remain eligible, your cash, food stamps or child care payment will be delayed.

If you want to appeal and your appeal request is received within 10 days of the mailing of this notice, you can continue to receive your cash, food stamps or child care payments until a hearing decision is made. For a full explanation of your rights to appeal and have a fair hearing, see the other side of this form.

TERMINATION NOTICE

If you do not comply with the above requirements, your Cash Assistance, your Medical Assistance and/or Food Stamps will be stopped unless you can show "Good Cause" for failing to do so. (55 PA Code 142.23(g), 133.84(d) and 7 CFR 273.12(a)(1)(vii)).

IF YOU NEED ANY HELP IN COMPLETING THIS FORM, CALL YOUR WORKER					
I swear that the information given is complete and correct to the best of my knowledge.					
	OR				
SIGNATURE (Payment Name)		SIGNATURE (Authorized Representative for Food Stamps or Responsible Household Member)			

INSTRUCTIONS

Remember to attach proof of income, resources, child care or sick/disabled person expenses. For income, proof is paystubs or employer's statement(s). Proof for self-employment income, renting rooms, apartments or furnishing board is paystub, employer's statements, personal or business records kept about renting rooms, apartments or furnishing board.

If you receive cash assistance and the Semiannual Reporting Form is late or incomplete for earned income, you will not receive any deductions (work incentive, work expenses, or child care) for cash assistance unless you can prove "good cause" (that is, it wasn't your fault that you did not report your earnings information). Loss of these deductions may affect your eligibility or the amount of your check and/or food stamps.

If you receive child care and you have not sent proof of child care costs, you or your provider will not be paid until it is received.

YOU MAY CLAIM "GOOD CAUSE" if you have a good reason for not being able to complete this form or for returning it late. To claim "good cause", you must state your reason(s) in the space provided, sign where indicated below and return this form to the county assistance office within **30 days** from the date of this notice. You may also claim "good cause" orally by contacting your worker, but you must still return this form to the county assistance office.

AM CLAIMING "GOOD CAUSE" BECAUSE:		DPW USE ONLY	
		APPROVED	NOT APPROVED
		SUP. AUTH	
	CLIENT SIGNATURE		

YOU HAVE THE RIGHT TO APPEAL AND TO HAVE A FAIR HEARING if you are dissatisfied with any decision to suspend or stop your benefits. At the hearing you can present the reasons for the appeal and present evidence or witnesses in your own behalf. You have the right to act for yourself or to have anyone act for you. A staff member of the county assistance office will refer you for free legal help upon request. You must request a hearing within 30 days from the date of this notice, except that appeals on food stamp changes must be received within 90 days from the beginning date of the change in your benefit. If your oral or written appeal is received within 10 days from the mailing date of this notice, the change will not be made. You will continue to receive your cash and/or medical benefits until the hearing decision is made or the end of your food stamps, you will continue to receive your food stamps until the hearing decision is made or the end of your food stamps eligibility period, whichever comes first. However, future eligibility and the amount of your cash and/or food stamps will be affected by other reported changes. If the final decision of the hearing officer is not in your favor, any cash assistance or food stamp benefits received until the hearing decision was made will be an overpayment and you may have to pay it back.

TO APPEAL AND REQUEST A HEARING FOR YOUR CASH ASSISTANCE, AND/OR MEDICAID BENEFITS, you may make an oral request by calling your worker BUT you must sign this form, state the reason(s) for your appeal and return this form to your county assistance office at the address shown on the reverse side of this form.

TO APPEAL AND REQUEST A HEARING FOR FOOD STAMPS, you may make an oral request by calling your worker **OR** sign this form, state the reason(s) for your appeal and return this form to your county assistance office at the address shown on the reverse side of this form or do both.

I AM APPEALING	G THE REQUIREMENT THAT I N	IUST TAKE PAR	T IN SEMIANNUAL REPORTING	BECAUSE:
SIGN HERE IF				
YOU ARE FILING AN	CLIENT SIGNATURE	DATE	CLIENT REPRESENTATIVE	DATE
APPEAL				
	TELEPHONE NO.		TELEPHONE NO.	

(USE THE ENCLOSED ENVELOPE TO RETURN THIS FORM)