LDSS-4732-A (2/11) **DFR COVER LETTER AND RESPONSE FORM** **NYSOTDA**

County Name and Address

TO: _____ FAX#:_____

_____

FROM: _____ FAX #: _____

_____ TEL.#:_____

CASE NAME: _____ DOB: ___/___/____ SS#: _____
(Last 4 Digits)

The above named individual applied for assistance on _____ . We believe that this client is the fiscal responsibility of your district. The documentation to support our belief is included in this fax. Please review this information and complete the section below indicating your district's response and fax to us as soon as possible but within 5 business days of receipt of our inquiry. If you have any questions, please contact:

_____ at _____

We (have) (have not) included a completed Documentation Form (DSS-2642) (or the approved local equivalent) indicating the eligibility documentation that we have requested from the applicant.

Complete if appropriate: The individual has been in a:

___ medical facility ___ non-medical residential facility

Facility Name: _____ Address: _____

___ We, _____ County, agree to accept fiscal responsibility for the above named individual.
Please complete the eligibility determination and forward the application and documentation to:

_____

___ We do not agree to accept fiscal responsibility for this individual. The reason for this decision is:

_____

_____

_____

Please contact _____ at _____
if you have any questions.

SIGNED:_____ DATE: _____