

Notice Date:
CIN:
Case Number:
Case Type:
Telephone:

Number of Weekly Hours Required for this activity:

Referring Worker:

Provider/Site:

Telephone:
Fax:

You are required to report:
For:

On:
At:

Offering Name:

Offering Contact:

Telephone:

Directions:

You are expected to appear as scheduled and to participate in activities as assigned. You are expected to immediately contact the referring worker if unable to appear as scheduled. Your failure to comply with the above requirement willfully and without good cause may result in loss or reduction of Public Assistance and Supplemental Nutrition Assistance Program - SNAP benefits and possible sanction per Office of Temporary and Disability Assistance Regulations 385.9 and 385.12. However, you are not subject to a SNAP sanction if you work and/or participate in work activities assigned by the social services district for at least 30 hours per week (totaling 120 hours per month.)

Provider Expectations: Please contact the referring worker immediately if client does not appear as scheduled or participate as assigned. Please contact the referring worker if a new appearance date or time must be arranged.

Signature: _____ Date: _____ Mailed Hand-Delivered