 

Date

Family Name
Address
City, State, ZIP

Dear HOH Name,

The FaDSS program received a referral for your family from Referral Source on Date. I have not been .

Please call me at Number at your earliest convenience, so we can discuss FaDSS in more detail. If  Date, your referral will be closed.

Sincerely,

Staff Signature

Phone Number

Email Address

Office Address

**Appeal Notice:**

You have the right to appeal decision(s) made in the FaDSS program. Appeals may be made by telephone or in writing to the FaDSS State Program Manager:
**Phone:** (515) 343-6459
**Mail**: FaDSS State Program Manager
 Lucas State Office Building, 3rd Floor
 321 E 12th St
 Des Moines, Iowa 50319
**Email**: FaDSS@hhs.iowa.gov