 

Date

Family Name  
Address  
City, State, ZIP

Dear HOH Name,

After conducting an eligibility review, we have determined that you do not meet the continued eligibility criteria for the FaDSS program. You may begin an optional three-month transition period beginning the first day of the month following the date of this decision.

At the end of the third month of transition, you will be exited from the FaDSS program. If your situation changes, you may request that your eligibility be reviewed again prior to the end of the transition period.

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](mailto:FaDSS@hhs.iowa.gov)