 

Date

Family Name
Address
City, State, ZIP

Dear HOH Name,

My name is      and I am a Title in the FaDSS program at Agency. .

I would like to meet with you on Date at Time in your home at Address. If this this time does not work for you, please contact me as soon as possible to reschedule.

Thank you,

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