



1-877-423-4746

NOTICE OF DECISION

Your Name
 Your Address
 Your City, State Zip

Worker ID:
 Worker Name:
 Worker Phone Number:

DATE: 10/11/2019

Case Number: 123456789

**Must be on or after
 1/1/2019**

Client ID:

Report Medicaid Fraud: 1-800-533-0686

Dear Your Name:

We have made a decision on your recent request for benefits.

Approval



Food Stamps

Your application for **Food Stamp** benefits dated 09/01/2019 has been completed. You have been determined eligible for Food Stamps for the months of September, 2019 **through** February, 2020.

For the month of XXX, 2019, you will receive \$XXX.XX.

For the month of XXX, 2019, you will receive \$XXX.XX.

For the months XXX, 2019 through XXX, 2020, you will receive \$XXX.XX.

You will receive your benefit on your issuance cycle of the 19th of each month.

Here are the eligibility decisions for each person included on the case:

Client Name: Your Name **Client ID: XXXXXX**

Program: Food Stamps

Benefit Month(s)	Decision
September, 2019	Eligible
October, 2019	Eligible
November, 2019 --- February, 2020	Eligible

Client Name: Child 1 **Client ID: XXXXXX**

Program: Food Stamps

Benefit Month(s)	Decision
September, 2019	Eligible
October, 2019	Eligible

NOTICE OF DECISION

Date:10/11/2019

Client Name: [REDACTED]

Client ID: [REDACTED]

November, 2019 --- February, 2020	Eligible
Client Name: Child 2	Client ID: XXXXXX
Program: Food Stamps	
Benefit Month(s)	Decision
September, 2019	Eligible
October, 2019	Eligible
November, 2019 --- February, 2020	Eligible

Client Name: Child 3	Client ID: XXXXXX
Program: Food Stamps	
Benefit Month(s)	Decision
September, 2019	Eligible
October, 2019	Eligible
November, 2019 --- February, 2020	Eligible