



Date
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To: \_\_\_\_\_ (Facility Name and Address)

\_\_\_\_\_

\_\_\_\_\_

From: Advisor
Office Address, Telephone No., and Fax No.

**Notification Letter**

The Texas Health and Human Services Commission (HHSC) determined that the authorized representative of your facility accessed Food Stamp Program benefits he was not entitled to. Benefits were improperly accessed as indicated below:

Client Name	Case Number	Date of Exit	Date Accessed	Reason Code	Benefit Amount

Code A – Benefits accessed after the client left the center  
 Code B – More than half of the benefits accessed before the 16th of the month

The total amount of benefits owed to HHSC is \$ \_\_\_\_\_ for the period of \_\_\_\_\_ to \_\_\_\_\_. A claim will be established for the repayment of benefits improperly accessed. Make checks payable and mail your payments to:

**Texas Health and Human Services Commission**  
 Fiscal Division (E-411)  
 P.O. Box 149055  
 Austin, TX 78714-9055

Submit payment within 30 days from the date listed above.  
 If you have any questions regarding this notification letter, please contact the advisor at the address or telephone number listed above.