Reset

South Carolina Department of Social Services

NOTIFICATION OF ELIGIBILITY DETERMINATION FOR REFUGEE RESETTLEMENT PROGRAM

From: _____ Date: _____

_____

_____

To: _____

_____

_____

Please Read the Statements Checked Below About Your Application for Assistance

Your application for Refugee Cash Assistance has been: ❑ Approved

You are eligible to receive benefits for the period of _____ to _____ .

For the month of Select Month ... you will receive $ _____ .

For the month of Select Month ... and after, you will receive $ _____ .

The check will be mailed to your present address. If you move, or if your income or household circumstances change, it is necessary that you notify Select County ... County Department of Social Services within 10 days at _____ .

Your Refugee Cash Assistance will be reduced effective: _____

Reason: _____

_____

Your application for Refugee Cash Assistance has been: ❑ Denied

Reason: _____

_____

❑ Your Refugee Cash Assistance will be terminated effective: _____

Reason: _____

_____

Fair Hearing

You may request a Fair Hearing before the State Department of Social Services if you do not agree with the action taken on your application or at any time you feel that an injustice has been done to you by the County Department of Social Services. The request for a hearing must be filed with us in writing within sixty (60) days from the date of this notice. You have the right to be represented at a hearing by an attorney or an authorized representative of your choice. Our office will be glad to help you request a hearing.

If you have questions about this notice, please contact _____

at _____ .
Telephone