DISQUALIFICATION INFORMATIONAL

CHECK LIST

SS # _____-_____-______

First name:________________

Middle Initial:____________

Last Name:_______________

Date of Birth____-___-____

Date of referral to DHHS:_____________

Reason for denial: Check all that apply: Start date :________ end date_______

- False representation
- Potential resource
- Work requirement
- Workfare
- Job fire
- Job quit

Contact person;____________________ Phone: #__________________

Municipality:______________________________

Narrative to help determine if the General Assistance client will lose his/her Food Supplement: