Letter Date

DLN

CLIENT NAME
[CARE OF PARENT NAME (IF CLIENT IS CHILD)]
MAILING ADDRESS
CITY, STATE, ZIP

Subject: You are approved for the Community Living Assistance and Support Services program.

Dear [Client Name]:

Medicaid Number:

We have approved you for the Community Living Assistance and Support Services (CLASS) waiver program. Your enrollment begins **MM/DD/YYYY**.

Your CLASS Case Management Agency is **PROGRAM PROVIDER'S FULL LEGAL NAME**.

Your CLASS Direct Services Agency is **DSA'S FULL LEGAL NAME**.

[*If applicable:* Your CLASS Financial Management Services Agency is **FMSA'S FULL LEGAL NAME**.]

[*If applicable:* Your CLASS Support Family Services Agency is **SFSA'S FULL LEGAL NAME**.]

[*If applicable:* Your CLASS Transition Assistance Services Agency is **TASA'S FULL LEGAL NAME**.]

If you have any questions, please call HHSC at 512-438-2484.

cc: <<LAR (if applicable)>>