SNAP 45DA
Rev. 10/25
05/14 Issue Obsolete

Louisiana Department of Health
Supplemental Nutrition Assistance Program

DRUG/ALCOHOL TREATMENT FACILITY MONTHLY ROSTER OF RESIDENTS RECEIVING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

FACILITY NAME: _____

MONTH: _____

Last Name	First Name	CID Number	Date of Birth	Date of Entry	Date of Departure	Date EBT Card Returned to Client/Consultant	(Date)	** Date E-mail Sent to Consultant to Report Departure
						☐ Client ☐ Consultant		
						☐ Client ☐ Consultant		
						☐ Client ☐ Consultant		
						☐ Client ☐ Consultant		
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						☐ Client ☐ Consultant		
						☐ Client ☐ Consultant		

** If the resident left the facility unannounced

_____ _____

Drug/Alcohol Treatment Facility Representative Date