[SHERIFF'S LETTERHEAD]

[Date]

NOTICE OF ASSESSMENT
LOCAL PROVIDER HEALTH CARE PROVIDER PARTICIPATION PROGRAM
FOR LINCOLN PARISH
Payments Due March 30, June 30, September 30 and December 30 _____

[Taxpayer] LPHCP Acct. No. _____
[Address]

Certified Mail Piece No._____

Dear [Taxpayer]:

Pursuant to La. R.S. 40:1248.1 *et seq* and Lincoln Parish Ordinance No. _____, you are hereby notified of your annual assessment for the privilege of doing business in Lincoln Parish as a local healthcare provider is:

Assessment Period: 202__
Assessment Amount: _____

This assessment must be paid in quarterly installments on or before the following dates or they may become subject to late payment penalties:

March 30, 202__
June 30, 202__
September 30, 202__
December 30, 202__

Please make all payments payable to the "Sheriff of Lincoln Sheriff, Local Provider Healthcare PPP" with a notation of your account number and assessment period. Mail your payment to:
"Sheriff of Lincoln Parish, Local Provider Healthcare PPP"
[mailing address for assessment payments]

Do not ignore this bill. Any questions should be directed to [program committee/contact name and number/email].

Sincerely,

[Name]
Civil Chief Deputy, Lincoln Parish Sheriff

DRAFT