



WAIVER OF RIGHT TO AN ADMINISTRATIVE DISQUALIFICATION HEARING

State Form 51934 (R3 / 5-13) / FI 2236

NOTICE OF CLIENT WAIVER

| | |
|-----------|-------------|
| To: | |
| Case name | Case number |

PLEASE READ THIS LETTER CAREFULLY. The purpose of this letter is to inform you that the _____ County Office of Family Resources is charging you with intentionally violating (*check one or both*) Food Stamp (FS) program / Temporary Assistance for Needy Families (TANF) rules and to allow you to waive (give up) your right to an Administrative Disqualification Hearing on these charges.

Committing any one of the following acts constitutes intentional program violation:

1. Making a false or misleading statement.
2. Misrepresenting, concealing, or withholding facts.
3. Violation of the Food Stamp Act, the Food Stamp program regulations, or any State statute relating to the unauthorized use, transfer, acquisition, receipt, or possession of Food Stamp benefits.

If you sign the attached Waiver of Right to an Administrative Disqualification Hearing and return it by the due date, no administrative disqualification hearing will be scheduled, but you will be disqualified from the Food Stamp / TANF programs and your benefits will be reduced.

Penalties imposed by administrative disqualification hearings for intentionally violating a Food Stamp/TANF program rule are listed below:

| PROGRAM | TYPE OF VIOLATION | LENGTH OF DISQUALIFICATION |
|---------|---|----------------------------|
| FS | First intentional program violation | One (1) year |
| FS | Second intentional program violation | Two (2) years |
| FS | Third intentional program violation | Permanent |
| FS | Making a fraudulent statement or representation about your identity or place of residence, and receiving duplicate benefits | Ten (10) years |
| TANF | First intentional program violation | Six (6) months |
| TANF | Second intentional program violation | One (1) year |
| TANF | Third intentional program violation | Permanent |

You may call the _____ County Office of Family Resources, at _____ if you have questions about the charges against you or the list of evidence on the Request for Administrative Disqualification Hearing (State Form 42686, FI 2235) enclosed with this letter. If you are interested in obtaining legal assistance, you may contact your local legal services organization.

If you choose not to sign this waiver, you will be notified later of the date and time of your administrative disqualification hearing.

IF YOU CHOOSE TO HAVE THE ADMINISTRATIVE DISQUALIFICATION HEARING, YOU HAVE THE RIGHT TO THE FOLLOWING:

Look at the evidence that will be used at the hearing, both before and during the hearing. Please call your local office if you wish to arrange to look at the evidence before the hearing.

Remain silent concerning the charge(s) brought against you by the County Office of Family Resources.

Present your own case or have someone present your case for you, such as a lawyer, friend, relative, or community worker.

Ask us to delay your hearing for up to thirty (30) days if you need more time to prepare your case.

Bring your own witness.

Argue your case freely.

Question any evidence or statement made against you.

Bring any evidence you may have that would support your case.

Once the administrative disqualification hearing is scheduled, you may request a postponement by contacting Hearings & Appeals. Unless the postponement is granted, the hearing will be conducted as scheduled, even in the event that you or your representative do not appear. In the event that you or your representative do not appear, the hearing decision will be based solely on the evidence that the County Office presents. If you or your representative fail to appear, you may contact Hearings & Appeals within ten (10) days after the hearing to present good cause. Except in the case of non-receipt of the notice, you or your representative will have thirty (30) days to claim good cause.

In addition to this hearing, the State or Federal Government is allowed to prosecute you in a court of law and the County will collect any overissuance.

WAIVER OF RIGHT TO AN ADMINISTRATIVE DISQUALIFICATION HEARING (continued)

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* This agency is requesting the disclosure of your Social Security number in accordance with 42CFR435.910, CFR273.6, and CFR205.52. Disclosure is voluntary and you will not be penalized for refusal.

| | |
|------------------------|--|
| Name of person charged | |
|------------------------|--|

| | |
|-------------|--------------------------|
| Case number | Social security number * |
|-------------|--------------------------|

I, _____, voluntarily choose to waive (*give up*) my right to an administrative disqualification hearing.

I understand that a waiver of the disqualification hearing will result in disqualification and a reduction in benefits for the period of disqualification, even if I do not admit to the facts as presented by the State agency.

I understand that the remaining household members, if any, may be held responsible for repayment of the resulting claim.

I have read and understand the information sheet concerning administrative disqualification hearings.

I have been provided with a notice of the charges against me and a summary of the evidence and how and where the evidence can be examined.

Check one of the following statements:

I admit to the facts as presented, and understand that a disqualification penalty will be imposed if I sign this waiver.

I do not admit that the facts as presented are correct. However, I have chosen to sign this waiver and understand that a disqualification penalty will result.

I do not choose to waive my right to an administrative disqualification hearing.

The following parties must sign in the spaces provided below for this waiver to be accepted. The person charged and the head of the household must sign if the person charged is not the head of the household.

| | |
|-----------------------------|---|
| Signature of person charged | Date signed (<i>month, day, year</i>) |
|-----------------------------|---|

| | |
|---|---|
| Signature of head of household (<i>if not person charged</i>) | Date signed (<i>month, day, year</i>) |
|---|---|

In order to avoid scheduling and convening the disqualification hearing, this signed waiver must be received by the local Office of Family Resources no later than _____.