COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Family Support

DATE: XX/XX/XXXX
CASE NUMBER: XXXXXXXXX

Head O Household
125 MY STREET
ANYTOWN, KY 40601

# VOLUNTARY WAIVER OF SNAP ADMINISTRATIVE DISQUALIFICATION HEARING

[~~Case~~] Name of Individual: ________________

Worker [~~Claim~~] Name: __________________________
Worker Phone: __________________________

The Cabinet for Health and Family Services (CHFS) believes that you, *(<accused individual>)*, committed an Intentional Program Violation (IPV) by giving wrong information about your household situation in order to get or to continue Supplemental Nutrition Assistance Program (SNAP) benefits.

The cabinet believes you committed an IPV because of this evidence:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________.
You can contact the worker listed above to review this evidence or if you need more information.

You have the right to an Administrative Disqualification Hearing where a hearing officer will decide if you committed an IPV. We cannot disqualify you from getting SNAP unless (1) the hearing officer decides that you committed an IPV or (2) you sign this waiver. If you sign this waiver, we will disqualify (or stop) you from receiving SNAP benefits for:

- ☐ **One (1)** year because this would be your 1st Intentional Program Violation.
- ☐ **Two (2)** years because this would be your 2nd Intentional Program Violation.
- ☐ **10 years** because this would be your 1st or 2nd Intentional Program Violation due to receipt of duplicate benefits based on your fraudulent statement or misrepresentation.
- ☐ **Permanently** because this would be your 3rd Intentional Program Violation for any of the above or any of the following:
  - A conviction in a federal, state, or local court for having used or received benefits in a transaction involving the sale of drugs;
  - A conviction in a federal, state, or local court for having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives; or
  - A conviction in a federal, state, or local court for having trafficked benefits in an aggregate amount of $500 or more.

To waive the Administrative Disqualification Hearing, fill out this form and return it by _______________ to avoid scheduling a hearing.

**Please return the form to:**

**DCBS**
**P.O. Box 2104**
**Frankfort, KY 40602**

You can also upload this form to the Self-Service Portal or return it to your local DCBS office.

You have the right to remain silent about these charges. Anything said or signed concerning the charges can be used against you in a court of law.

You have the right to legal help or advice. You may be able to get FREE legal help from your local Legal Aid Office by calling (   ) _________.

## WAIVER

If you want to waive your right to a hearing, you may check one of the following statements and sign below:

- ☐ **I admit to the facts as presented and understand that I will be disqualified for the time period on page 1 if I sign this waiver.**

- ☐ **I do not admit that the facts presented are correct. However, I still want to sign this waiver and understand that I will be disqualified for the time period on page 1 if I sign this waiver.**

**You** and any other household members 18 years and older during the period of overpayment **are responsible for repayment of any incorrect or overpaid SNAP benefits**.

We will reduce future SNAP benefits to recover the amount owed. Failure to repay the amount owed could result in the state sending this matter to court for appropriate action.

If you are not the head of the household, the head of the household must also sign this agreement.

______________________________________________________________________
SIGNATURE OF INDIVIDUAL DATE

______________________________________________________________________
SIGNATURE OF HEAD OF HOUSEHOLD (IF NOT THE SAME) DATE

[~~Address ______________________________________~~
~~______________________________________________~~

~~You have the right to a hearing to decide if you committed fraud. You may accept the agency's proof that you committed fraud and give up your right to a hearing.~~
~~If you want to give up your right to this hearing OF YOUR OWN FREE WILL, this form must be filled out and given to or mailed to the DCBS office no later than ________________. If this form is not returned by this date, your hearing will be scheduled.~~

~~If you want a hearing, write your name below and do not complete the rest of the form:~~

~~I, __________________________ have read this notice but still choose to have an administrative hearing to tell my side.~~
~~(Your Name)~~

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~~I, _______________________ have read this notice and freely give up my right to an Administrative Disqualification Hearing.~~
~~(Your Name)~~

~~**CHECK ONE BLOCK ONLY.**~~

~~[ ] I admit that I intentionally violated the rules of the Supplemental Nutrition Assistance Program (SNAP). I understand that I shall not get benefits for ___________________ if I sign this form.~~

~~[ ] I do NOT admit that I intentionally violated the rules of the SNAP. However, I choose to sign this form~~

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~~and understand that I shall not get benefits for _________________ if I sign this form.~~

~~**I UNDERSTAND** that I have the right not to say anything about these charges and that anything I say or sign about the charges, including this form, may be used against me in a court of law.~~
~~**I UNDERSTAND** that if I sign this form, I shall not get benefits for myself for the time period shown above and that benefits to the other members of my household may be less or stopped even if I do not admit to the facts as given by the agency.~~
~~**I UNDERSTAND** that I am responsible for paying back the benefits received that I was not eligible to get.~~
~~**I UNDERSTAND** that the household members who are still getting benefits, if any, are also responsible for paying back the benefits received that the household was not eligible to get.~~
~~**I UNDERSTAND** that I have the right to ask for a Fair Hearing if I disagree with the amount you say I owe.~~
~~**I UNDERSTAND** that the penalty remains the same whether I choose to have a hearing and I am found guilty or if I choose to waive my right to a hearing.~~

~~**DO NOT SIGN THIS FORM UNLESS YOU HAVE RECEIVED AND READ "NOTICE OF SUSPECTED INTENTIONAL PROGRAM VIOLATION"**~~

~~**Recipient Signature**___________________________________________ Date________________________~~
~~If the person signing above is not the head of the household, then the head of the household shall also sign this form.~~

~~**Signature of Head of Household**____________________________________ Date________________________~~

~~YOU HAVE THE RIGHT TO LEGAL HELP OR ADVICE. You may be able to get FREE LEGAL HELP from your local legal aid office at the following telephone number (___) _____________.~~

~~The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)~~

~~If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.~~

~~Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).~~

~~For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm .~~

~~USDA is an equal opportunity provider and employer.~~

~~You may also file your complaint with the Cabinet for Health and Family Services, Office of Human Resource Management, EEO Compliance Branch, 275 East Main Street, 5C-D, Frankfort, Kentucky 40621 or call (502) 564-7770 ext. 4107.~~

~~If you have other complaints about your SNAP case, you may call the Ombudsman's Office at (800) 372-2973 or (800) 627-4702 (TTY).~~

~~FOR OFFICE USE ONLY~~

~~(Worker's Name)~~ ~~(Worker's Address)~~

~~(Worker's Phone No.)~~ ~~(Date Notice Received)~~]