Administrative Disqualification Hearing (ADH) Scheduling Request Form

NEW YORK STATE OF OPPORTUNITY. | Office of Temporary and Disability Assistance

To: New York State Office of Temporary and Disability Assistance
Administrative Disqualification Hearing Unit
P.O. Box 1930, Albany, New York 12201-1930

From: (Name of County/NYC Agency Originating Request)

Name of Accused Individual *(Recipient)*: **Language/Dialect:**

Address: **City:**

State: **Zip Code:** **Phone:** **Date of Birth:**

Social Security Number: **Case Number:**

If recipient currently resides in county other than county originating request,
please enter county of residence:

If New York City case, enter JC# / SC#: and check originating office:

☐ Bureau of Fraud Investigation (BFI) ☐ Bureau of Eligibility Verification (BEV)

If any other individual(s) is charged in this IPV, please provide name:

and Social Security Number:

(Note: Joint case must be submitted with a separate Administrative Disqualification Hearing (ADH) Scheduling Request Form and packet per individual.)

Is this case currently active? If no, enter date of case closing:

How was address verified (e.g., postal clearance, home visit, DMV records, etc.):

This Intentional Program Violation is based on the following action: (Please place check mark in the application box(es))

DUPLICATE BENEFITS	UNDECLARED INCOME	UNDECLARED RESOURCES	FALSE APPLICATION INFORMATION	UNREPORTED HOUSEHOLD COMPOSITION CHANGES	OTHER
☐ SNA (180)	☐ SNA (181)	☐ SNA (182)	☐ SNA (183)	☐ SNA (184)	☐ SNA (185)
☐ FA (180)	☐ FA (181)	☐ FA (182)	☐ FA (183)	☐ FA (184)	☐ FA (185)
☐ SNAP (430)	☐ SNAP (431)	☐ SNAP (432)	☐ SNAP (433)	☐ SNAP (434)	☐ SNAP GENERAL (435)
					☐ SNAP TRAFFICKING (467)

Indicate the IPV amount for this case: PA: $ SNAP: $

Period of over issuance: PA: SNAP:

Previous number of PA-IPV's: While receiving FA: SNA:

Previous number of SNAP-IPV's:

Penalty requested: PA: SNAP:

Date(s) Recipient committed IPV: Date Social Services District discovered the IPV:

Telephone number for Recipient/Representative to call to arrange to examine all documents and records to be used at a hearing:

Place where Recipient/Representative can examine all documents and records to be used at a hearing:

Name and Title of County/NYC Agency Referring Staff:

Phone *(Area Code)*:

Name of Agency Representative who will be presenting at the fair hearing:

Phone Number where Agency Representative presenting at the fair hearing can be reached:

Attestation of Review of Administrative Disqualification Hearing Evidentiary Packet

Name of County/NYC Agency:

Name of Recipient:

Case Number:

Date:

By signing below, I attest that:

1. I have reviewed the attached evidentiary packet for recipient named above, and
2. I am not the Eligibility Worker assigned to the recipient's household, and
3. The attached evidentiary packet contains sufficient documentary evidence to substantiate that the recipient above has committed one or more intentional program violations in accordance with the standards described in Section 18 NYCRR 359.3, and
4. The attached evidentiary packet satisfies the provisions of 18 NYCRR 359.5 (e) and OTDA GIS # (the ADH Demonstration Project).

Name:

Title/Position:

Date: