## Administrative Disqualification Hearing (ADH) Scheduling Request Form



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

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

Name of Accused Individual (Recipient): Language/Dialect: Address: City: State: Zip Code: Phone: Date of Birth: Case Number: **Social Security 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** UNDECLARED **UNDECLARED FALSE APPLICATION** UNREPORTED HOUSEHOLD OTHER **BENEFITS INCOME RESOURCES INFORMATION COMPOSITION CHANGES** SNA (181) SNA (182) SNA (183) SNA (184) SNA (185) SNA (180) FA (180) FA (183) FA (185) FA (181) FA (182) FA (184) **SNAP GENERAL** SNAP (430) SNAP (431) SNAP (432) SNAP (433) SNAP (434) (435)

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:

SNAP TRAFFICKING

(467)

Telephone number for Recipient/Represent	tative 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 Ref	ferring Staff:
Phone (Area Code):	
Name of Agency Representative who will be presenting at the fair hearing:	
Phone Number where Agency Representat	tive 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	
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	
• •	the provisions of 18 NYCRR 359.5 (e) and OTDA GIS # e ADH Demonstration Project).
Name:	
Title/Position:	
Date:	