ES-524
Rev. 02-17

FOOD ASSISTANCE DISQUALIFIED RECIPIENT REPORT

INSTRUCTIONS: Complete this form and email to DCF.EBTMAIL@ks.gov within 20 days of the disqualification date. Retain original in the case file.

TYPE OF ACTIVITY (CHECK ONE) ☐ ADD ☐ CHANGE ☐ DELETE

1. NAME (Do not exceed maximum line length)

Last Name _____

First Name _____ Middle Initial _____

2. SOCIAL SECURITY NUMBER _____ **3. DATE OF BIRTH** _____
MO DAY YR

4. SEX ☐ Female ☐ Male **5. METHOD OF DISQUALIFICATION** ☐ ADH ☐ Court

6. CASE NUMBER _____

7. DISQUALIFICATION NUMBER

☐ 1 = First Disqualification ☐ 2 = Second Disqualification ☐ 3 = Third Disqualification

8. TYPE OF OFFENSE AND LENGTH OF DISQUALIFICATION

Type (check one)	Length (check one)
☐ A. Drug Trafficking Conviction < $500 KEESM 11221.1(4)	☐ 24 Months ☐ Permanent
☐ B. Trafficking Conviction (including drugs) > $500 KEESM 11221.1(6)	☐ Permanent
☐ C. Firearms Trafficking Any Amount KEESM 11221.1(5)	☐ Permanent
☐ D. Trafficking (Administrative Disqualification Hearing) KEESM 11221.1(1,2 or 3)	☐ 12 Months ☐ 24 Months ☐ Permanent
☐ E. Duplicate Participation KEESM 11221.1(7)	☐ 10 Years
☐ F. Fraud (ADH, Court Conviction, Civil Judgment, Disqualification Consent Agreement or Waiver of Right to Administrative Disqualification Hearing) KEESM 11221.1(1,2 or 3)	☐ 12 Months ☐ 24 Months ☐ Permanent

9. DISQUALIFICATION DECISION DATE _____
MO DAY YR

10. DISQUALIFICATION START DATE _____
MO DAY YR

11. COUNTY WHERE CASE FILE IS LOCATED _____

12. REMARKS _____

PREPARED BY (Signature) _____ Phone _____ Date _____