REFERRAL FOR AN ADMINISTRATIVE DISQUALIFICATION HEARING ES-3112
10-16

Date: _____ Service Center: _____

Case Name: _____ Case Number: _____

Name of the individual alleged to have committed
fraud (if different from the case head): _____

Address: _____

City/State/ZIP: _____

Programs and Amount of Overpayment: (Check boxes that apply.)

☐ Food Assistance $ _____ ☐ TANF $ _____ ☐ CC $ _____

Dates of the alleged violation (attach a copy of the overpayment summary)

_____ Date of Discovery: _____

Summary of the Circumstances: _____

Summary of Documentary Evidence to be presented at the hearing (attach one copy of each): _____

Number of prior fraud disqualifications, including dates and manner in which the fraud was determined in each:

Food Assistance: _____

Child Care _____

Name(s) of Agency Representative(s) who will be presenting the evidence (include title):

FOR DCF ADMINISTRATION USE ONLY

Date Received: _____

Comments: _____

Disposition:

Signature Date

Signature of Second Party Reviewer Date

Distribution: One copy to Administrative Hearings; one copy to Case File.
This form supersedes IM-3112, dated 11-97.