BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF KANSAS
DEPARTMENT OF ADMINISTRATION

1-03

WAIVER OF RIGHT
TO ADMINISTRATIVE DISQUALIFICATION HEARING

I understand that I am entitled to an Administrative Disqualification Hearing regarding alleged fraudulent actions on my part. I understand that I am entitled to waive the Administrative Disqualification Hearing and that, should I choose to do so, I will be disqualified from the **FOOD ASSISTANCE TANF GA** program(s) in the same manner as any person found to have committed fraud after having been provided such a hearing.

I understand that I have no method for appealing my disqualification after I have signed this waiver. I further understand that I have the right to remain silent concerning the charges which have been made against me and that anything said or signed by me concerning the charges may be used against me in a court of law. I further understand that I am not required to sign this waiver, and if I refuse to sign it, I cannot be adversely affected or more severely penalized for not signing this waiver.

I understand that if I sign this waiver, I will be disqualified from participating in the **FOOD ASSISTANCE TANF GA** program(s). I also understand that to sign this waiver means that I am agreeing to pay back in full the amount of assistance benefits, which the state agency alleges were fraudulently overissued. Furthermore, I understand that the remaining assistance household members, if any, will be responsible for repayment of the overissuance.

I am aware that if I have any questions concerning the charges being made against me and/or the implications of signing this waiver, I may call the person identified below for more information.

Person _____ Telephone Number _____

Therefore, I wish to make the following statement: (please check one)

_____ I admit to the facts as presented, and I understand that a disqualification penalty will be imposed if I sign this waiver and I agree to make full restitution of the amount of assistance benefits that were overissued.

_____ I do not admit that the facts as presented are correct. However, I have chosen to sign this waiver and understand that a disqualification penalty will result, and I agree to make full restitution of the amount of assistance benefits that were overissued.

I also understand that this waiver is effective only if I sign and return it to the Office of Administrative Hearings, 1020 S. Kansas Avenue, Topeka, Kansas, 66612-1327, no later than _____.

Name: _____ Date: _____

If the person accused of committing fraud is not the head of the household, the head of the household must also sign this waiver.

Name: _____ Date: _____

CASE NO. _____