Public Assistance Disqualification Waiver

I understand I am accused of an intentional violation of public assistance program rules. I have the right to a hearing to contest this charge. By signing this form, I waive my right to an administrative disqualification hearing and agree to be disqualified from receiving public assistance benefits as determined by the program rules.

Personal Information

Full Name:

Address:

Case Number:

Last 4 digits of SSN:

Applicant Acknowledgment

I certify that I have read and understand this waiver. I understand the consequences of signing this waiver and have been given an opportunity to ask questions.

Signature:

Date:

Witness (if required)

Witness Signature:

Date: