NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services
WAIVER OF DISQUALIFICATION HEARING

LOCAL AGENCY :___________________________
DATE: ___________________________
CASE NO: ___________________________
FOOD AND NUTRITION SERVICES: _______
WORK FIRST: _______ (*check appropriate programs)*

Name:
Address:

You have been notified of our intent to have a hearing to decide if you committed an Intentional Program Violation. If you do not want to have a hearing, you must sign the bottom of this form and return it to us by _____________________. If you are not the head of your household, the person who is head of household must also sign this waiver.

You are not required to sign this waiver. However, if you do sign, the signed form or verbal statements may be used against you in a court of law. You will also be disqualified from participation in the program for__________________________ and a reduction in benefits will occur for the disqualification period. This disqualification will begin the first month following the date the household received notification of the disqualification. Any adult household members who remain eligible after you are disqualified will also be held responsible for the repayment of the amount you owe. If you have questions, you can call this office at ____.
Please check the statement you are agreeing to and sign below.

_________ **I admit to the facts as presented. I understand that a disqualification penalty will be applied if I sign this waiver.**

Signature **Date**

Signature of head of household (if different) **Date**

_________ **I do not admit to the facts as presented. However, I have chosen to sign this waiver and understand that a disqualification penalty will result.**

Signature **Date**

Signature of head of household (if different) **Date**

Signature of County Representative **Date**

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Economic and Family Services