



**TANF/SNAP/CCAP NOTICE OF SUSPECTED
INTENTIONAL PROGRAM VIOLATION**
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1940 (1-2025)

Case Number	Date
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See instructions on page 6.

TO: Program Applicant/Recipient

Name		
Street Address/PO Box		
City	State	ZIP Code
Telephone Number		

FROM: Human Service Zone

Name		
Street Address/PO Box		
City	State	ZIP Code
Telephone Number		ext.

We think you intentionally violated program rules. This form tells you about disqualification, hearings and how to waive a hearing. If you have any questions regarding this notice, please call the number listed above.

We recently reviewed your:

- Temporary Assistance for Needy Families (TANF)
- Supplemental Nutrition Assistance Program (SNAP)
- Child Care Assistance Program (CCAP)
- CCAP Provider Participation

We think you did the following:

(Attach pages as needed)

We have the following information to support these charges:

(Attach pages as needed)

You and your authorized representative may see this information at the human service zone office. To arrange a time, call the human service zone office.

Because we think you committed an intentional program violation, we propose to disqualify you from the:

<input type="checkbox"/> TANF <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanently	<input type="checkbox"/> SNAP <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanently	<input type="checkbox"/> CCAP <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanently	<input type="checkbox"/> CCAP as a Provider <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanently
<input type="checkbox"/> 10 Years Fraudulent Misrepresentation of Residence	<input type="checkbox"/> 10 Years Fraudulent Misrepresentation of Residence		
Eligibility Staff Signature (electronic signature is acceptable)		Title	Date

By signing this form, I certify the evidence has been reviewed and the form completed correctly by the eligibility staff.

Supervisor/Director/Signature (electronic signature is acceptable)	Title	Date
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THE REMAINDER OF THIS FORM CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHTS.

PLEASE READ THIS ENTIRE FORM

You have the right to remain silent concerning the charge(s). Anything said or signed by you concerning the charge(s) can be used against you in a court of law.

Regardless of whether a hearing is requested or held, the state or federal government may prosecute you for an intentional program violation in a civil or criminal court action and may collect any overpayment of benefits.

If you agree the information is true or if you accept the disqualification without a hearing, you must sign the "Waiver of Hearing" below. This form must be signed and returned by _____. If the "Waiver of Hearing" is not received by this date, a hearing will be held.

If you waive your right to a hearing, we will disqualify you from the program(s) and the period(s) checked on page 2 of this form.

If you choose to waive the hearing, by signing this form, we will reduce TANF, SNAP or CCAP benefits for your household. All adult household members are responsible for repayment of overpayment of benefits.

If you waive a hearing as a CCAP Provider, you will be ineligible to receive payment from CCAP for any services provided during the disqualification period.

**PAGE 4 OF THIS FORM CONTAINS ADDITIONAL
INFORMATION ABOUT YOUR HEARING RIGHTS AND PROCEDURES**

WAIVER OF HEARING

THE WAIVER WILL RESULT IN YOUR DISQUALIFICATION AND A BENEFIT REDUCTION FOR OTHER HOUSEHOLD MEMBERS IN TANF SNAP CCAP FOR THE PERIOD OF DISQUALIFICATION.
 THE WAIVER WILL RESULT IN YOUR DISQUALIFICATION AS A CCAP PROVIDER FOR THE PERIOD OF DISQUALIFICATION.

If a signed 'Waiver of Hearing' is received by the Appeals Supervisor, Department of Health and Human Services, 600 East Boulevard Avenue, Dept. 325, Bismarck, ND 58505-0250 before the date of the hearing, no hearing will be held. The waiver must be signed by the person for whom IPV is being pursued against **and the caretaker relative or head of household if the person for whom IPV is being pursued is not the caretaker relative or head of household.** The child care provider or director of the child care facility for which IPV is being pursued must sign the waiver.

Sign A or B below if you wish to waive a hearing.

A. I admit to the facts as presented and understand that a disqualification penalty will be imposed if I sign this waiver.		B. I do not admit that the facts as presented are correct. However, I have chosen to sign this waiver and I understand that a disqualification penalty will result.	
Your Signature	Date	Your Signature	Date
Caretaker Relative/Head of Household Signature	Date	Caretaker Relative/Head of Household Signature	Date

ABOUT HEARINGS

If you have witnesses who have testimony or evidence in their possession which is necessary to your case, you may, before the hearing, ask the Administrative Law Judge to prepare subpoenas ordering those witnesses to appear at the hearing to testify or to bring the needed evidence. You will have to see that your subpoenas are properly served.

It is important that you or your representative be at the hearing, otherwise a decision will be based solely on information provided by the human service zone office.

If you or your representative do not appear at the hearing and there is a good reason why you or your representative did not attend the hearing, you must contact the Administrative Law Judge within 10 days after the hearing date in order to determine if you are entitled to receive a new hearing date.

Your hearing will be conducted by telephone unless you request that the administrative law judge be present. You are entitled to have the Administrative Law Judge present if you wish. If you request to have the Administrative Law Judge present, it will not affect the way the hearing is conducted or the decision.

I request that an Administrative Law Judge be present at my hearing. **(Do not sign if you have waived your hearing. Do not sign if you prefer a telephone hearing.)**

Name	Signature	Date

YOUR HEARING RIGHTS AND PROCEDURES

1. For telephone hearings, the Administrative Law Judge will place a telephone call to your hearing location. All locations will have a speaker-phone system in which all parties will be able to hear and speak without having to use a telephone receiver.
2. The hearing will be conducted in an impartial manner. All testimony will be submitted under oath and tape recorded. You will not be bound by the rules of procedure and evidence used in the courts. Any papers you submit will be sent to the Administrative Law Judge for examination.
3. You must appear at the time and place set forth on your notice, along with any witnesses or representatives you choose. The human service zone representative(s) and witnesses will also be present. Attendance by other persons must be agreed to by both you and the human service zone office. An interpreter shall be provided by the human service zone office if the Administrative Law Judge determines this is necessary.
4. You may look at the evidence that will be used at the hearing both before and during the hearing. Call the human service zone office if you wish to look at the evidence before the hearing.
5. You may present your own case or have a lawyer, friend, relative, or community worker present your case for you.
6. You may ask to delay your hearing for up to 30 days if you need more time to prepare your case provided such request is made to the Administrative Law Judge at least 10 days in advance of the scheduled hearing.
7. You may bring your own witnesses.
8. You may argue your case freely.
9. You may question any statements made against you or any evidence.
10. You may bring any evidence you may have that would support your case.
11. You may refuse to answer any questions or to make any statements.
12. Free legal services may be available to you at an office listed on the attached page.
13. A copy of the Administrative Rules on hearing procedures is available, upon request, from the Appeals Supervisor.

Additional Comments

INSTRUCTIONS FOR COMPLETING SFN-1940

The SFN 1940 is intended to notify an individual in writing when the individual is suspected of committing an IPV. The form advises the individual of their hearing rights and hearing procedures, allows the individual the right to waive the hearing, and allows an individual to request a hearing officer be present at the hearing rather than having a telephone hearing.

Page 1:

1. Enter the case number and date.
2. Enter the name and current address of the individual suspected of IPV. There may be occasions when more than one individual is suspected of giving a false report or they were interviewed together. In those cases, prepare a separate SFN 1940 for each individual.
3. Enter the current Human Service Zone Office name, address and telephone number.
4. Indicate the program(s) or CCAP provider reviewed.
5. Describe the violation of program rules including the information that was deemed as incorrect, the facts which were not revealed by the individual including how and when information and verifications were submitted by the individual.

Page 2:

1. Enter the evidence disputing the accuracy of the individual's statements, including when and where the evidence came from. This can also include when and with whom discussions were conducted and the outcomes of which may contradict the individual's statements. Enter what documents were provided that should have included information not revealed and when they were submitted by the individual. Document how the individual was aware of the reporting requirement(s).
2. Choose the program(s) or CCAP Provider. Check for prior violations and **indicate the number of years the disqualification is for.**
3. The form must be signed by the person who is completing the form.
4. The form must be signed by a supervisor, director, or human service zone representative after reviewing the evidence and form for accuracy.

Page 3:

1. **Enter the date the form must be signed and returned. The return date must be 10 days from the date of the scheduled IPV meeting the human service zone is required to conduct.**
2. Indicate which program(s) or CCAP Provider the waiver is applicable for.
3. The individual suspected of IPV has the choice to sign Waiver A, Waiver B, or to not sign the form. If the individual suspected of IPV is not the Head of Household or Caretaker Relative and has signed the form; the Head of Household or Caretaker Relative must also sign the form.

Page 4:

1. The individual suspected of IPV can request an Administrative Law Judge be present at the hearing rather than a telephone hearing by signing in the "About Hearings" section on page 4.

Page 5:

1. The individual suspected of IPV can add their comments to the form.