Georgia Department of Human Services
Division of Family and Children Services
FOOD STAMP PROGRAM SANCTION/PENALTY NOTICE

_____ County Department of Family and Children Services

Date _____

Name _____ Client ID #_____

Address _____ Case # _____

_____

Free Legal Services Call _____

Worker Name/ID_____

Dear Sir/Madam: _____[Head of Household]

Your Food Stamps will change from $_____ to $_____ effective _____ for the reason listed below.

_____ will stop receiving food stamps effective _____, because _____ failed to comply with food stamp work requirements, see below:

____Voluntarily quit a job without good cause or voluntarily reduced work hours to less than 30 hours per week without good cause

____Refused or failed to comply with employment and training program requirements

_____

[_____] **SNAP WORKS PROGRAM SANCTION APPLIED**

_____ failed/refused to meet his/her SNAP WORKS Program work requirement for the month of _____(month/year).

The above name individual failed/refused to (provide reason):
_____

_____

_____ is ineligible for food stamp benefits at least from _____ to _____or until compliance or exemption from work registration or participation. This is the [___] violation. If the person above complies with the SNAP Works Program requirements before the effective date of the sanction, the sanction will not be

imposed. The sanction may be lifted before the end of the sanction period if _____ becomes exempt from or complies with the work requirements.

Following the above minimum sanction period, the individual may take the following action to become eligible for benefits again:

- Reapply for benefits and provide all required information to determine eligibility;
  AND
- Comply with food stamp work requirements

You may contact your caseworker to obtain information about complying with the food stamp work requirements.

[_____] **VOLUNTARY QUIT/REDUCTION OF THE WORK EFFORT SANCTION APPLIED**

_____ failed/refused to meet his/her food stamp work requirement for the month of _____.The above name person voluntarily quit a job without good cause or voluntarily reduced work hours to less than 30 hours per week without good cause.

_____is ineligible for food stamp benefits from _____ to _____ or exemption from work registration requirements. This is the [_____] violation. The sanction indicated above may be lifted before the end of the sanction period if _____ becomes exempt from or complies with the work requirements. NOTE: Voluntary Quit/Reduction of the Work Effort Sanction is lifted following the minimum sanction period.

You may contact your caseworker to obtain information about complying with food stamp work requirements.

[_____] **PENALTY FOR FAILURE TO PERFORM A REQUIRED ACTION APPLIED:**

If you are a TANF recipient and have failed/refused to comply with a TANF work or personal responsibility requirement, your food stamp benefits cannot increase because of the TANF action. Your prior TANF amount of $_____ will continue to be budgeted in your food stamp case from _____ to _____. If your TANF case is closed, this food stamp penalty will be applied for no longer than 12 months.

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I WANT TO REQUEST A HEARING

If you are dissatisfied with the decision made on your case, you may request that the Department of Human Services hold a fair hearing to review the action that the Division of Family and Children Services is taking in regard to your Food Stamp Program benefits.

The reason I want a hearing is:

_____
_____
_____
_____

Please check the correct box if applicable:

If you request a hearing within 14 days from the date of this notice, you may continue your food stamp benefits at the pre-hearing request level until your next periodic review.

□ I do not want to continue to receive the benefits I now receive while I am waiting for the hearing decision.
□ I want to continue to receive the benefits that I now receive while waiting for the hearing decision.

I understand that I may be required to repay the Department of Human Services for any overpayment in FS benefits to which I was not entitled as determined by the Hearing Officer.
NOTE: Food stamp benefits are not continued at the pre-hearing request level beyond the next periodic review. If benefits are denied at application or the periodic review, benefits are not continued.

Signature of Person Requesting Hearing _____ Date:_____

Telephone Number Where You Can Be Reached _____

If you want to request a hearing, sign above and return this form to the Division of Family and Children Services.

Hearing Procedures

You may request a hearing either orally or in writing by notifying the Division of Family and Children Services. You have 90 days from the date on this form to request a hearing. The hearing is held for the Food Stamp Program by a representative of the Office of State Administrative Hearings. Any member of the staff will be glad to furnish the necessary forms, help you file your hearing request, and assist you in every way possible to prepare for the hearing. You may be represented at such a hearing by an authorized representative such as legal counsel, a relative, friend or other spokesperson or you may represent yourself. Free legal services may be available to you in your community. If you are interested in legal services, call the free legal services' number listed on the front of this form.