Investigative Unit Operations Plan

County: Chautauqua County

Contact Person: Cindy Bly

Title: Principal Social Welfare Examiner

Phone #: (716)753-4870

E-mail Address: BlyC@co.chautauqua.ny.us

1. What unit is responsible for the investigation of client fraud allegations?

Please provide the name of the unit, # of positions, titles of positions, and how allegations are processed.

The organizational unit responsible for the investigation and prosecution of allegations of client fraud is, The Chautauqua County Department of Health & Human Services (DHHS) – Program Integrity Unit.

The Chautauqua County Program Integrity Unit consists of the following positions:

1- Principal Social Welfare Examiner (PSWE)
2- DHHS Investigators
3- Social Welfare Examiners
4- Operations Assistant
5- Typist II

*With contracts for:

1-Deputy Sheriff Investigator
1-Assistant District Attorney

The Program Integrity Unit receives fraud referrals from staff of various divisions throughout the agency. Also from the public through the Chautauqua County DHHS Welfare Fraud Hotline, E-mail Tips through the Chautauqua County Sheriff’s Office website, Web Fraud referrals from Office of Temporary Disability Assistance Office (OTDA), New York State Office of Medicaid Inspector General’s office and the New York State Office of Welfare Inspector General’s office. The referrals are then reviewed by either the PSWE or the DHHS investigators to ensure that the alleged information was not previously reported to the agency by the client. If information had not been previously reported, an
investigation packet is then made up and assigned to the Deputy Sheriff Investigator that is currently assigned to the Program Integrity Unit. The Assistant District Attorney who is currently assigned to the Program Integrity Unit also receives a copy of the entire investigative packet that was given to the Deputy Sheriff Investigator. The Deputy Sheriff Investigator then conducts a thorough investigation, which could include meeting with the client and the taking of a voluntary statement from the client. The Assistant District Attorney, Deputy Sheriff Investigator and PSWE meet at least on a monthly basis to review the status of the current investigations and any investigation packets that have been subsequently completed by the Deputy Sheriff Investigator. At this point in time the Assistant District Attorney may request calculations be made on an investigation packet and brought back to the next scheduled meeting before a determination of how the agency will proceed with investigation packet. If not, discussion is held on each case and a determination of how the agency is to proceed. If to be criminally charged, an arrest packet is completed and given to Deputy Sheriff Investigator to issue appearance tickets to client for court date to answer the charges. Some cases, the Assistant District Attorney may recommend a Disqualification Consent Agreement for TA/SNAP cases be offered and if client is unwilling to sign the DCA, the client will then be issued appearance tickets by the Deputy Sheriff Investigator. For some cases, the Assistant District Attorney may recommend a Voluntary Admission Agreement (VAA) for a childcare benefits case and a repayment agreement for Heap benefits. (Attached you will find copies of Referral Forms used by Chautauqua County)

2. What unit is responsible for the prosecution of client fraud allegations?

Please provide the name of the unit, # of positions, titles of positions, and how allegations are processed.

Same answer as listed for question 1.

3. What unit is responsible for determining the overpayment amount, establishing the claim, and collection activities?

The Program Integrity Unit is responsible for determining the fraud overpayment and establishment and collection of claims.

Fraud Overpayments:

A Program Integrity Social Welfare Examiner calculates the overpayments for all Intentional Program Violations, Disqualification Consent Agreements, Voluntary Admission Agreements and client errors that are discovered by the Program Integrity Unit. The calculations are reviewed by the Principal Social Welfare Examiner before the agency proceeds with any further action: whether criminal or not. For agency errors and client errors (that are not discovered by the Program Integrity Unit) the Social Welfare Examiners in the other divisions whether TA/SNAP/Childcare will be responsible to calculate overpayment, send notification to client and complete and forward a New CAMS Claim form to the Program Integrity Unit, which will then be entered into CAMS to establish the claim.
Claims Establishment-Collection of Claims:

The Program Integrity Unit is responsible for entering all new CAMS claims, modifications to existing claims, sending out monthly & bi-monthly billing statements for cases that are no longer receiving assistance, turning any cases over to collection agency and for entering of all cash receipts. (Attached are copies of the CAMS forms that are used in Chautauqua County. Overpayment/Overissuance Referral (New Claim) and CAMS Maintenance Referral (Established Claim)

4. What are the step by step procedures for the referral of fraud cases for administrative hearings, including the notices provided and the timing of providing such notices?

Chautauqua County Program Integrity Unit does not process any fraud cases through the administrative hearing process.

5. What are the step by step procedures for the referral of fraud cases to your District Attorney, including the notices provided and the timing of providing such notices?

The referrals are then reviewed by either the PSWE or the DHHS investigators to ensure that the alleged information was not previously reported to the agency by the client. If information had not been previously reported, an investigation packet is then made up and assigned to the Deputy Sheriff Investigator that is currently assigned to the Program Integrity Unit. The Assistant District Attorney who is currently assigned to the Program Integrity Unit also receives a copy of the entire investigative packet that was given to the Deputy Sheriff Investigator. The Deputy Sheriff Investigator then conducts a thorough investigation, which could include meeting with the client and the taking of a voluntary statement from the client. The Assistant District Attorney, Deputy Sheriff Investigator and PSWE meet at least on a monthly basis to review the status of the current investigations and any investigation packets that have been subsequently completed by the Deputy Sheriff Investigator. At this point in time the Assistant District Attorney may request calculations be made on an investigation packet and brought back to the next scheduled meeting before a determination of how the agency will proceed with investigation packet. If not, discussion is held on each case and a determination of how the agency is to proceed. If to be criminally charged, an arrest packet is completed and given to Deputy Sheriff Investigator to issue appearance tickets to client for court date to answer the charges. Some cases, the Assistant District Attorney may recommend a Disqualification Consent Agreement for TA/SNAP cases be offered and if client is unwilling to sign the DCA, the client will then be issued appearance tickets by the Deputy Sheriff Investigator. For some cases, the Assistant District Attorney may recommend a Voluntary Admission Agreement (VAA) for a childcare benefits case and a repayment agreement for Heap benefits.
6. What are your procedures for offering a Disqualification Consent Agreement (DCA)?

Once the Assistant District Attorney assigned to the Program Integrity Unit has previously reviewed the case and has made a determination of a Disqualification Consent Agreement is to be offered to the client in question, clerical staff in the Program Integrity Unit will send out an appointment letter with 10 Day Notification of Consequences and the Disqualification Consent Agreement before the client is asked to sign a Disqualification Consent Agreement. The appointment is scheduled for a minimum of 13 days into the future. The appointment is set up at one of the three office locations that would be geographically located closest for the client to attend. The appointment is only ever scheduled with the Principal Social Welfare Examiner. Once the client is in the office for the appointment, the Principal Social Welfare Examiner will thoroughly explain the Disqualification Consent Agreement and answer any questions that the client may have prior to signing the Disqualification Consent Agreement. Once the Disqualification Consent Agreement is signed, the Principal Social Welfare Examiner will then discuss signing a repayment agreement. If a SNAP overpayment, prior to the signing of a repayment agreement for the SNAP overpayment amount, the Principal Social Welfare Examiner will also discuss the Treasury Offset Program (TOP) so that the client is aware of the guidelines. If the client does not consent to signing the Disqualification Consent Agreement, the Principal Social Welfare Examiner will advise the client that the agency may continue the investigation and that criminal charges may be forthcoming. **The Program Integrity Unit will then move forward with the processing of an arrest packet for the Deputy Sheriff Investigator as the investigation has already been discussed at case conference previously with the Assistant District Attorney, Deputy Sheriff Investigator and the Principal Social Welfare Examiner. It is our policy to arrest if client will not sign the Disqualification Consent Agreement. (Attached are copies of the DCA appointment letter, Notice of Consequences of Consenting to a Disqualification Consent Agreement and Disqualification Consent Agreement)

7. How is it proven that an individual has been advised on the court record of the Public Assistance disqualification penalties?

The Assistant District Attorney assigned to the Program Integrity Unit is in court whenever the accused client is before the judge. The Statement for the Record is read to the client by the presiding Judge and entered into court record. Prior to sentencing, the client is advised of the disqualification periods that can be imposed. Also at this time, the court provides the client with a copy of the Statement for the Record and the client signs a copy of the Statement for the Record as does the judge and it is entered into the court proceedings. (Please see attached Order Entering Statement into Record and Statement for the Record)

Attach a copy of the agreement between your social services district and the District Attorney's Office for the prosecution of welfare fraud.
CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
INVESTIGATION REFERRAL

(Check One)

☐ FRONT END DETECTION (FEDS)

APPLICATION DATE: _____________

INTERVIEW DATE: _____________

FEDS REFERRAL

COMPLETED DATE: _____________

CASE NAME: ____________________________

SS NUMBER: ____________________________

ADDRESS: _____________________________

CATEGORY: FA SNA SNAP HEAP
(Circle Which Applies)

CASE NUMBER: ___________________________

WORKER: _____________________________

EXT: ________

OFFICE: D MJ
(Circle One)

REASON FOR FEDS REFERRAL:

☐ Working off the books (currently or previously).

☐ Financial Obligation are current, but stated expenses exceed income without a reasonable explanation.

☐ Prior history of denial, case closing or overpayments resulting from investigation.

☐ Application inconsistent with prior information

☐ Supported by loans or gifts from family/friends.

☐ PO Box is used as a mailing address without specific explanation.

☐ No absent parent information or information is inconsistent with application

☐ No indicators

STOP HERE FOR FEDS REFERRALS

FOR BEDS REFERRAL ONLY

☐ QUESTIONABLE HOUSEHOLD COMPOSITION

☐ UNREPORTED INCOME/RESOURCES

☐ QUESTIONABLE RESIDENCE/LIVING ARRANGEMENTS

COMMENTS: ____________________________________________________________

______________________________________________________________
CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
INVESTIGATION REFERRAL-CARD CHILD CARE

(Check One)
☐ FRONT END DETECTION (FEDS) APPLICATION DATE:______________
☐ BACK END DETECTION (BEDS) INTERVIEW DATE:______________

FEDS REFERRAL COMPLETED DATE:______________

CASE NAME:_________________________ SS NUMBER:______________
ADDRESS:_________________________ CASE NUMBER:______________

________________________________ CASE TYPE: TA TRANS LOW INCOME

PLACE OF EMPLOYMENT OR TRAINING SCHOOL ________________________________

PROVIDER'S NAME:_________________________ FORMAL INFORMAL
ADDRESS:_________________________ PH:__________

WORKER:_________________________ EXT:__________ OFFICE: D M J
(Circle One)

REASON FOR REFERRAL: (Check Which Applies)

☐ Applicant is self-employed, but cannot provide adequate business records.

☐ Applicant has history of denial, case closing or overpayment resulting from an investigation.

☐ Applicant states he/she working off the books.

☐ Information of application is inconsistent with prior case information.

☐ Documentation or information provided by applicant is inconsistent with the application.

☐ Child Care provider lives in the same household as the child.

☐ No absent parent information or information is inconsistent with application.

☐ PO Box supplied as a mailing address without reasonable explanation.

☐ No Indicators

COMMENTS:__________________________________________

____________________________________
HOTLINE CALL

Date: ____________________  Time of Call: _______________

CLIENT NAME: ____________________________

ADDRESS: ________________________________

Case Number ____________________________

Complaint:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
OVERPAYMENT/OVERISSUANCE REFERRAL
(NEW CLAIM)

[[ □ SNAP (A3) ENTRY or □ TA (A4) NON SNAP ENTRY]]
[[CAMR # ____________________]]

□ ACTIVE CASE (Recoup-10, link-11)

□ CLOSED CASE (bill-21)

ASSISTANCE GROUP (see back):

□ 1-SNAP  □  2-TA  □  3-Child Care
□ 4-PA/not FA, SN □  6-MA

CASE NUMBER: ______________________

CASE TYPES:

□ 11 FA  □ 17 SN Non Cash  □ 20 MA
□ 16 SN  □ EAF/ESN  □ 22 MA-SSI
□ 12 FA/SN, Non-Cash  □ Long Term
□ 20 MA-SSI  □ 31 SNAP  □ 60 HEAP
□ Care

□ FHP  □ 40 SERVICES
□ 32 SNAP-MIX

CASE NAME: ______________________ SSN: ______________________

OTHER HH ADULT/SPOUSE: ______________________ SSN: ______________________

ADDRESS:

__________________________________________________________

CLAIM ESTABLISHMENT REASON CODE: _________________
(see back)

OVERPAY PERIOD: ___/___/___ TO ___/___/___

CLAIM OVERPAYMENT CODE:
(see back)

□ 1-Agency □ 2-Client □ 3-Fraud/IPV
□ 4-Advanced pmt □ 6-Energy Reconcile
□ C-Aid to Continue

OVERPAY CLAIM AMOUNT:

$_________ (PA)

$_________ (MA)

$_________ (SNAP)

$_________ (CHILDCARE)

CLAIM DISCOVERY DATE: ___/___/___

CLAIM ESTABLISHMENT DATE: ___/___/___

BRIEF EXPLANATION OF CIRCUMSTANCES WHICH LED TO OVERISSUANCE:

__________________________________________________________________________

CNS Notice # ______________________ Manual Letter Sent (Y) (N) (circle one) Imaged (Y) (N)

□ ORKER ______________________ DATE ______________________ EXT _______________
CAMS MAINTENANCE REFERRAL
(ESTABLISHED CLAIM)

CASE NUMBER: ______________________ CAMS CLAIM NUMBER: ______________________

CASE NAME: ______________________ SSN: ______________________

☐ Case closing on: ______________________

Balance Due: $ ______________________ (Z1) Change collection method to 21

Send bills to: ______________________

☐ Client moved to another county. Destination county: ______________________

Will client be likely to apply for assistance in that county? ☐ Yes ☐ No

☐ Co-op case. NPA to PA/FS, etc. (B1) Recoupment case number: ______________________

☐ Case reopening – Claim# ______________________ Claim balance: $ ______________________ (B3)

Change collection method to 10

☐ Responsible party not in case. Add case# ______________________

☐ OR send bills to: ______________________ (Z1)

☐ Claim no longer available for collection. Terminate (Code T)

Reason: ______________________

Explanation: ______________________

☐ * Manual recoupment for the month of ______________________ for the amount of $ ______________________

Reason for recoupment: ☐ Single issuance ☐ $0 Budget

☐ Other.
Explain: ______________________

Worker: ______________________ Date: ______________________ Ext: ______________________

Supervisor Signature: ______________________

* Any requests for a manual posting require the signature of a supervisor.
October 23, 2015

Re: Disqualification Consent Agreement

Dear:

Enclosed please find paperwork regarding a Disqualification Consent Agreement pertaining to the time period of in which you failed to notify the Department of Health & Human Services that , resulting in an overpayment amount of .

You have been scheduled for an appointment with of the Program Integrity Unit of the Department of Health & Human Services on at the Department of Health & Human Services. At that time we will discuss a repayment agreement for the monies owed to this agency and the enclosed Disqualification Consent Agreement. If you fail to show to the scheduled appointment, we will assume that you do not want to sign a Disqualification Consent Agreement and repayment agreement and may move forth with criminal action.

If you cannot attend the appointment at the above time, you will need to contact me immediately at . Thank you for your cooperation into this matter.

Very truly yours,
NOTICE OF CONSEQUENCES OF CONSENTING
TO A DISQUALIFICATION CONSENT AGREEMENT
Pursuant to 18 NYCRR 359.4(b)

PLEASE TAKE NOTICE THAT:

* You or a member of your family or household have been suspected and accused of committing an intentional program violation (IPV) by making a false or misleading statement or committing an act intended to mislead, misrepresent, conceal or withhold facts concerning your eligibility for public assistance and/or the Supplemental Nutrition Assistance Program (SNAP).

* When a social services official believes that there are facts that warrant civil or criminal prosecution for such an IPV, the official must refer a case involving an IPV to the appropriate District Attorney (DA) or other prosecutor.

* A DA or other prosecutor who accepts a case referred by a social services official may choose to settle a referred case by permitting the accused individual, a caretaker relative or a head of household to sign a Disqualification Consent Agreement (DCA) instead of seeking a criminal conviction of the accused individual.

* Pursuant to an agreement with the DA or other appropriate prosecutor(s), you must be given notification of the consequences of signing a DCA before you can be given an opportunity to enter into such an agreement. If the DA or other prosecutor has requested social services officials to assist in obtaining a DCA from you, you must be provided with this notification at least ten (10) days before signing a DCA and you must be provided with an opportunity to consult with and be represented by a lawyer or other representative.
A copy of the DCA you may or may not choose to sign must accompany this notification and this copy of the DCA must set forth the specific penalties and consequences that will occur if you sign this agreement. If you choose to sign this agreement, you will be disqualified from and unable to be eligible for participation in public assistance as follows:

**Public Assistance**

[] for 6 months because this was the first time you committed a public assistance-IPV and you wrongfully received an amount less than $1,000.

[] for 12 months because this was the second time that you committed a public assistance-IPV, or you wrongfully received between $1,000 and $3,900.

[] for 18 months because this was the third time you committed a public assistance-IPV, or you wrongfully received over $3,900.

[] for 5 years because you have committed three or more previous public assistance-IPV(s).

**The Supplemental Nutrition Assistance Program (SNAP)**

[] for 1 year because this was the first time you committed a SNAP-IPV, and it was not a drug or firearms or explosives-related offense.

[] for 2 years because this was the second time you committed a SNAP-IPV that was not a drug or firearms or explosives-related offense; or because this was your first SNAP-IPV and it is based on a Court finding of trafficking in controlled substances for coupons.

[] permanently because this was the third time that you committed a SNAP-IPV that was not a drug or firearms or explosives-related offense; or because this was your second SNAP-IPV and it is based on a Court finding of trafficking in controlled substances for coupons; or because this was your first SNAP-IPV and it is based on a Court finding of trading in firearms, ammunition, or explosives for coupons.

[] Other (Enter)
Your eligibility for other assistance programs, such as Medical Assistance or other Social Services assistance or services, may be affected if you must be eligible for public assistance in order to receive the particular assistance or services.

If you are not getting public assistance now, your disqualification penalty will be effective when you are eligible and apply for assistance again. For SNAP, your disqualification penalty will begin on the date it is imposed.

If you sign the DCA, you also will be held responsible for repaying the stated amounts of any overpayments of assistance paid to you, or the overissuance value of any Food Stamps issued to you. This repayment amount should be the amount of assistance received by you which is more than the amounts of assistance that you should have received. If there are other members of your family or household that will remain eligible for assistance during any period when you will not be eligible, those remaining members of the assistance unit will be held responsible for repayment of the overpayment and/or overissuance stated in the DCA unless you already make the identified repayment.

If you choose not to sign this DCA, the DA or other prosecutor may choose to continue the criminal prosecution of your case or the case may be returned to social services officials for consideration of administrative prosecution by means of an administrative disqualification hearing as described in social services regulations 18 NYCRR 359.7.

If you choose to sign this DCA or would like to discuss the consequences of signing this Agreement, on or before the below stated time, you must contact:

Name: _____
Address: _____
Telephone: _____
Date and Time: _____

If you do not contact or appear before the named person or do not contact a social services official in charge of this matter, it will be assumed that you have chosen not to sign a DCA and any pending investigations or prosecutions may be resumed.
* We encourage you to consult with a lawyer before signing the Agreement. The Local Legal Services Office in your area is:

**Legal Aid of Chautauqua Region**  
111 West Second Street  
Jamestown, NY 14701  
716-483-2116

The Local Public Defender is:  
HRC Building  
7 North Erie Street  
Mayville, NY 14757  
716-753-4376
DISQUALIFICATION CONSENT AGREEMENT

The undersigned individual(s) understand and agree that:

1. I or a member of my family or household have been suspected and accused of committing an intentional program violation (IPV) by making a false or misleading statement or committing an act intended to mislead, misrepresent, conceal or withhold facts concerning my or my family’s eligibility for Public Assistance, and/or the Supplemental Nutrition Assistance Program (SNAP).

2. I have received notification of the consequences of consenting to this Disqualification Consent Agreement (DCA) and certify that I understand the consequences of consenting to this DCA.

3. I am suspected and accused of committing one or more IPV(s) as follows:

   Public Assistance - Resulting in an overpayment in the amount of $\_

   Supplemental Nutrition Assistance Program (SNAP) - Resulting in an overissuance amount valued at $\_

4. I agree to repay to social services officials the amounts received as overpayments or the value of amounts received as overissuances of food stamps as follows:

5. If I choose to sign this agreement, I will be disqualified from and ineligible for participation in assistance programs as follows:
PUBLIC ASSISTANCE

☐ For 6 months because this was the first time that I committed a public assistance-IPV and I wrongfully received an amount less that $1,000.

☐ For 12 months because this was the second time that I committed a public assistance-IPV, or I wrongfully received between $1,000 and $3,900.

☐ For 18 months because this was the third time that I committed a public assistance-IPV, or I wrongfully received an amount over $3,900.

☐ For 5 years because I have committed three or more previous public assistance-IPV(s).

If I am not eligible for public assistance from which I am disqualified at the time the disqualification period is to begin, the period will be postponed until I become eligible for such benefits.

Supplemental Nutrition Assistance Program (SNAP)

☐ For 1 year because this was the first time I committed a SNAP-IPV, and it was not a drug or firearms or explosives-related offense.

☐ For 2 years because this was the second time I committed a SNAP-IPV that was not a drug or firearms or explosives-related offense; or because this was my first SNAP-IPV and it is based on a Court finding of trafficking in controlled substances for coupons.

☐ Permanently because this was the third time that I committed a SNAP-IPV that was not a drug or firearms or explosives-related offense; or because this was my second SNAP-IPV and it is based on a Court finding of trafficking in controlled substances for coupons; or because this was my first SNAP-IPV and it is based on a Court finding of trading in firearms, ammunition, or explosives for coupons.

☐ Other (Enter)

For SNAP, the disqualification period will begin on the date that the penalty is imposed.
6. The remaining members of my assistance unit will be held responsible for repayment of the overpayment and/or overissuance stated in the DCA, unless I already have made the identified repayment.

7. Further prosecution by social services officials of me regarding the IPV(s) described in this DCA will be deferred pending the performance of the terms of this Agreement and the charges will be withdrawn and/or dismissed upon complete performance of the terms of this Agreement.

For Individual(s) to be disqualified:

Date_______ Signature_____________________________________

Date_______ Signature_____________________________________

For a public assistance-IPV if the individual(s) (is) (are) not the caretaker relative:

Date_______ Signature_____________________________________

Caretaker Relative

For a FS-IPV if the individual(s) (is) (are) not the head of household:

Date_______ Signature_____________________________________
STATE OF NEW YORK       COUNTY OF CHAUTAUQUA

CITY COURT : CITY OF JAMESTOWN

ORDER ENTERING
STATEMENT INTO
RECORD

Upon examining the accompanying Statement for the Record, and having advised the defendant on the record of the disqualification provisions contained in Section 145-c of the Social Services Law in accordance with the requirements of subdivision 4 of section 145-c of the Social Services Law and paragraph (5) of subdivision (d) of section 359.9 of title 18 of the State of New York Codes, Rules and Regulations, it is hereby

ORDERED that the said Statement for the Record be and hereby is ENTERED into the record of these proceedings.

____________________________
JUDGE.
STATE OF NEW YORK: COUNTY OF CHAUTAUQUA

CITY COURT: CITY OF JAMESTOWN

People of the State of New York
-VS-

DEFENDANT

STATEMENT FOR THE
RECORD

STATEMENT
To advise Individuals on the record of Disqualification's Provisions
Contained in Social Services Law Section 145-c
and Regulations at 18 NYCRR 359.9

If you or a member of your family or household enter a plea of guilty or are convicted of making a false or misleading statement or committing an act intended to mislead, misrepresent, conceal, or withhold facts concerning your eligibility for the Safety Net program, the Aid to Dependent Children assistance program, Medicaid Program, Child Care Program and or the Food Stamps assistance program, you may be determined to have committed an intentional program violation which may result in your being disqualified from participating in those assistance programs.

If you are determined to have committed an intentional program violation in either Safety Net assistance program or the Family Assistance program, you will also be unable to receive Safety Net assistance for a time period of six months times the total number of Safety Net and Family Assistance intentional program violations you have been determined to have committed.

In addition, if you are determined to have committed an intentional program violation in the Family Assistance program, you will also be unable to receive Family Assistance, Safety Net Program, Medicaid Program, Child Care Program or Food Stamps for a period of six months for the first violation or if the overpayment is under $1,000.00, twelve months for the second violation, or if the overpayment is between $1,000.00 and $3,900.00, eighteen months for the third violation, or if the overpayment is greater than $3,900.00 and five years for any violation after the third time.

If you are determined to have committed an intentional program violation in the Food Stamps assistance program, you will be unable to receive Food Stamps assistance for twelve months for the first violation, twenty-four months for the second violation, and permanently for the third time. In addition, two years for first conviction of trading a controlled substance, for Food Stamps permanent disqualification for the second time convicted, permanent for convictions of trading firearms, ammunition or explosives for Food Stamps, permanent for conviction of knowingly using, transferring, acquiring, altering or possessing Food Stamps coupons, authorization to participate cards or access devices in any unauthorized manner, and a ten years for making a false statement about identity or place of residence in order to receive multiple benefits.

If you are determined to have committed an intentional program violation in either the Safety Net assistance program or the Family Assistance program, your eligibility for other assistance programs, such as Medical Assistance, Child Care Assistance, Emergency Assistance, or other Social Services assistance or services, may be affected if you must be eligible for the Family Assistance or Safety Net in order to receive the particular assistance or services.

If you are not getting benefits now, your disqualification penalty will be effective when you are eligible and apply for assistance again. If you are determined to have committed an intentional program violation, you also will be held responsible for repaying any overpayments of assistance paid to you, or the overissuance value of any Food Stamps issued to you. This repayment amount should be the amount of assistance received by you, which is more than the amount of assistance that you should have received. If there are other members of your family or household that will remain eligible for assistance during any period when you will not be eligible, those remaining members of the assistance unit will be held responsible for repayment of the overpayment and/or overissuance unless you already make the identified repayment.

This statement is offered on the record to satisfy the requirements of subdivision 4 of Section 145-c of the Social Services Law and paragraph (5) of subdivision (d) of Section 359.9 of Title 18 of the State of New York Codes, Rules, and Regulations.
MEMORANDUM OF UNDERSTANDING

Assistant District Attorney Assigned to DSS for Fraud Prosecutions

This Memorandum of Understanding is made as of January 1, 2015 by and between the following parties:

DISTRICT ATTORNEY: CHAUTAUQUA COUNTY DISTRICT ATTORNEY
Chautauqua County Courthouse
Mayville, New York 14757-1000
hereinafter called "DA,"

-and-

SOCIAL SERVICES: CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
Division of Social Services
A Department of the County of Chautauqua, New York
Hall R. Clothier Building
Mayville, New York 14757-1027
hereinafter called "DSS."

WITNESSETH:

WHEREAS, DSS has undertaken aggressive efforts to prevent welfare fraud in Temporary Assistance, Child Care and Medicaid programs and desires to enhance these efforts, and

WHEREAS, DA has extensive expertise in prosecuting persons who commit welfare fraud, and

WHEREAS, DSS and DA believe if they join their efforts together they can effectively reduce welfare fraud in Chautauqua County,

NOW THEREFORE, the parties agree as follows:

1. Services. In cooperation with DSS, DA shall assign an assistant district attorney experienced in the crime of welfare fraud. Such employee will be located at DSS' offices in Mayville, Jamestown, and Dunkirk as necessary and appropriate. Such employee shall continue to be an employee of DA and shall continue to report to DA or duly authorized subordinate. The
Commissioner of Social Services shall have organizational supervision of the staff assigned hereunder and may have input into the assignment, retention, and reassignment of any such staff, however, DA shall retain ultimate authority over such assigned staff. The employee assigned by DA shall be responsible to prosecute welfare fraud and to advise DSS employees on criminal law and shall perform such other necessary services as assigned by DA and the DSS Commissioner.

DSS will refer all cases to DA’s office in which it is believed all facts warrant a civil or criminal prosecution. The DA’s office will be provided with documentary evidence which sustains DSS allegations and a Statement for the Record will be included in the evidence packet. The DA’s office will notify DSS in writing if there is not sufficient evidence to pursue the case and the DA’s office will notify DSS in writing of the outcome of the criminal case.

DA and DSS each agree to provide reports, documents, and other information that will enable the other party to perform its duties under this Agreement. All information exchanged between agencies is confidential and shall be used only for the intended purposes. Each party shall take appropriate measures to safeguard the confidentiality of such information to the extent required by any applicable state and federal laws and regulations. In addition, any disclosure of confidential HIV-related information shall be accompanied by the following written statement:

“This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized
further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient to authorize further disclosure".

Measures shall be taken to safeguard the confidentiality of such information to the extent required by applicable state and federal laws and regulations. All applicable records hereunder shall be kept for a period of six (6) years and shall be available upon request, except and excluding "Intake Only" records which may be destroyed after one (1) year and may not be made available to anyone provided however that such records may be made available for audit purposes to the NYSDFA; New York State Audit and Control, DHHS and USDA.

2. Term. This Agreement shall commence as of January 1, 2015, and shall terminate December 31, 2015, provided either party may cancel or terminate this Agreement in whole or in part at any time upon at least thirty (30) days advance written notice to the other party, with accounts between the parties to be adjusted and prorated as of such termination date.

3. Payment. DSS shall reimburse DA the amount of One Hundred Twenty Thousand Eight Hundred Twenty-six and No/Dollars ($120,826.00) for services herein for a salary in the amount of Seventy-three Thousand Five Hundred Twenty and No/Dollars ($73,520.00) and fringe benefits in the amount of Forty-seven Thousand Three Hundred Six and No/100 Dollars ($47,306.00) as detailed in Appendix A attached hereto. DSS consents that said amount shall be charged back by payroll each pay period commencing as of January 1, 2015, against DSS accounts A.6010.1100 and A.6010.-.8000, however, that the amount allocated to DA by DSS is based upon DSS receiving, at a minimum, the equivalent of thirty-three and ninety-five
hundreths (33.95) hours in any pay period and the amount to be
allocated to DA will be reduced proportionately by the number of
hours the under thirty-three and ninety-five hundreths (33.95)
per pay period provided to DSS by DA's office.

4. **Statutory Compliance.** DSS and DA shall perform in ac-
cordance with all applicable federal, state, and local laws,
rules and regulations. All statutory provisions applicable to
this Agreement are hereby incorporated by reference, including
but not limited to the Civil Rights Act of 1964 as amended by
Executive Order 11246, 41 CFR Part 60, Section 504 of the
Rehabilitation Act of 1973 and 45 CFR Parts 84 and 85.

5. **Non-Discrimination.** Neither party shall discriminate
or permit discrimination against any individual or group on the
grounds of age, race, creed, color, national origin, sex,
religion, disability, or marital status.

6. **Entire Agreement.** This Agreement contains the sole and
entire agreement between the parties relating to the services
provided hereunder and shall supersede any and all other agree-
ments between the parties. Any other statements or representa-
tions made by either party are void and have no force or effect.

IN WITNESS WHEREOF, the parties have executed this Memoran-
dum of Understanding as of the date first written above.

CHAUTAUQUA COUNTY DISTRICT ATTORNEY

BY   DATE 2/5/15

David Foley, District Attorney

CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES,
Division of Social Services

BY   DATE 2/12/15

Christine Schuyler, Commissioner of Human Services

Approved:

DATE 1-30-15

Vincent W. Horrigan, County Executive
DSS FRAUD PROGRAM – D.A. COSTS – 2015

1 Prosecutor (97% FTE)

Wages: $73,520
Fringe: $47,306

TOTAL Expenses $120,826