Georgia Department of Human Services
Division of Family and Children Services

Claims Repayment Agreement

Date:_____

Name:_____

Address:_____

_____

_____

PLEASE READ THE STATEMENTS BELOW CAREFULLY. BE SURE YOU UNDERSTAND THEM BEFORE YOU SIGN THE FORM.

If you have any questions, contact your county/regional claims manager at _____.

I understand that I have received an overpayment in the following amount of $ _____ in the program of _____.

I understand that this is a legal debt that must be repaid even though it may not have been my fault. I also understand that everyone in my household who was 18 years old or older and receiving assistance at the time the overpayment occurred is responsible for repaying this debt.

I understand that if my case closes, I must make minimum monthly payments to the Centralized Payment Processing Center at P.O. Box 2666, Atlanta, GA 30301.

I understand that if payments are not received timely after my case closes, my state tax refund and/or my federal tax refund and certain other federal benefits may be held to pay on this debt.

I understand that if benefits, in addition to my regular monthly allotment, are owed to me from past months or in future months, these benefits will be applied to this debt.

I understand that I may also use benefits from my EBT card to make payments.

Please select from the options listed below and return this repayment agreement within 14 days of the date of this notice.

- ❑ My case is closed. My first payment will be made on _____. I understand that each payment thereafter will be due within 30 days of the previous payment.

- ❑ I am receiving benefits now. I know that a percentage that has been set by law will be subtracted automatically for this debt each month. I know that if my case closes, I must begin making the minimum monthly payment of $_____ every 30 days beginning the month after the case closes.

- ❑ I receive benefits now. I know that a percentage will be subtracted from my benefits each month. In addition to that amount, I want the following amount withheld each month: _____

- ❑ I want to pay the entire amount at one time via certified check or money order.

- ❑ I would like to pay my claim using benefits from my EBT account. **(Upon receipt of this agreement, additional forms would be provided to you.)**

I understand that the Georgia Department of Human Services may use other collection methods to secure repayment of my debt, and I hereby consent to the use of this Agreement as evidence against me for the repayment of my debt(s) above any situation, including criminal and civil actions, relating to and/or involving the amounts owed. I also understand that the Georgia Department of Human Services may authorize the Internal Revenue Service (IRS) and/or the Georgia Department of Revenue to withhold any refund due to me to repay my debt if I do not make payments as scheduled above.

I understand that this agreement does not preclude criminal prosecution or civil action; even if all outstanding balances are paid and it is determined that I have committed an intentional program violation classified under state and federal statutes as fraud.

_____ _____

Client Signature Date

_____ _____

Claims Manager Signature Date