Georgia Department of Human Services
EBT CLAIM PAYMENT AGREEMENT

Name _____ County _____

Address _____ Worker _____

_____

_____

Phone Number _____

Case Number _____ Claim Number _____

Last 4 digits of social security number _____

I authorize the Georgia Department of Human Services to deduct up to but not exceeding _____dollars ($_____) from my Food Stamp EBT Account (for FS over issuances only)

I understand that the decision to repay my debt with EBT benefits is voluntary and that I may cancel this request at any time prior to the close of the next business workday _____
Date

I understand that this payment is in addition to any automatic recoupment from my benefits.

_____ _____

Client Signature **Date**

_____ _____

County Representative Signature **Date**

****

I want to cancel my request dated_____to deduct a claim payment from my EBT account.

_____ _____

Client Signature **Date**

****

Claim payment confirmation in the amount of _____ dollars ($_____)

_____ _____

State Office Claims Representative **Date**

Form 269 (Rev. 10-2020)