NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services
LETTER OF OVERPAYMENT

Notification of Claim

Program Case ID

Claim Type:

County Case ID

It has been determined that you or your household received $ more AFDC/Work First than you were eligible to receive during the months of

due to:

You must pay back the extra AFDC/Work First you received.

Your Responsibilities

ALL ADULT HOUSEHOLD MEMBERS ARE EQUALLY LIABLE FOR THE CLAIM

You must make every effort to pay the full amount you owe. If you have not previously made arrangements for full repayment, and cannot pay the full amount now, you must make arrangements for full repayment.

The amount you owe may be collected from all countable income and assets of the family unit, including the family's gross countable income, liquid assets, and the Work First cash assistance payment. If you are currently receiving Work First cash assistance and have not previously made arrangements for full repayment, the amount of Work First you receive each month will be reduced until the claim is paid in full. The amount of the reduction will be based on the family's total countable income. The Work First family will be allowed to retain income of at least 90% of the maximum Work First payment received by a family of the same size with no other income. The amount of the reduction may change if your Work First payment changes. You may make an additional cash payment by contacting your local department of social services.

Unless written arrangements to repay the amount of the claim are made, the debt will be referred to the North Carolina Department of Revenue for collection through State income tax refund intercept.

Hearing Process

If you disagree with the amount of the claim, the recoupment amount, or you believe the claim has been paid in full, you may have a local hearing. At the hearing, you will have the opportunity to explain why you disagree. A Hearing Officer will then make a decision on the case. If you do not agree with the decision, you may request a second hearing with a State official. You can continue to receive Work First at your current rate if you request a hearing by . However, you may later be required to repay some of these benefits.

You have 60 days (or 90 days, if you have good reason for delay), from the date of this letter to request a hearing. The 60th day is . If you do not request a hearing by this date, you are not allowed to have one. To request a local hearing, contact the local department of social services at or, complete and return the form below. You may also contact this office to find out more about how a hearing works.

Your Rights

The household has the opportunity for a local hearing on the validity and amount of the claim. At this time the household is provided the opportunity to inspect and copy agency records and review with the agency the circumstances relating to the claim.

Free legal advice may be available in your county. Contact your local legal services office to inquire.

Arrange for Payments

If you are not actively receiving Work First cash assistance, and have not previously made arrangements for full repayment, you must choose a method of repayment by checking the appropriate box below. You must then sign and return this form to the Work First office within 10 days. If you fail to return this signed form or contact the Work First office within 10 days, the county will initiate further collection action. This action may include, but not be limited to, civil court action, State tax refund intercept, or wage garnishment. Collection of this overissuance may be referred to a private collection agency. You may be required to pay delinquent or processing fees, if applicable. Your first payment is due 30 days from the date of this notice.

☐ I agree to make full repayment in the form of a lump sum cash payment.

☐ I agree to make monthly cash payments in the amount of $ each and every month until such time as the claim is paid in full.

Signed _____

Date _____

Si necesita ayuda para entender esta carta de notificación de un pago excesivo, comuníquese con la unidad de integridad de este programa en el departamento de servicios sociales del condado indicado arriba.

If you want a local hearing, fill out this form, cut it off, and mail to:

_____
Name of person requesting hearing

_____
Address

_____ _____ _____
Telephone number where you can be reached | Your Signature | Date

Use this space to tell us why you want a fair hearing

_____

FOR OFFICE USE ONLY

Program Case ID_____ County Case No. _____ Claim Worker_____

Date Notice Sent _____ Date Request Received _____

DSS-8226 (06/02)
Economic Independence Section

Lea el reverso de esta forma en Espanol