

FORM I.D.
RECEIPT NO.
P

CO. CASE NO.

COUNTY DEPARTMENT OF SOCIAL SERVICES

REFUND RECEIPT

CO. NO.	CASE I.D./LIEAP I.D.	CD	CASEHEAD/PAYEE NAME FIRST	MI	LAST	JR/SR/ETC.
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SIS I.D. (CPPS ONLY)	NCFAST PDC#

CHILD'S NAME (CPPS ONLY) FIRST	MI	LAST	JR/SR/ETC.

REASON FOR REFUND
07 <input type="checkbox"/> SUSPECTED FRAUD
10 <input type="checkbox"/> OTHER NON-QC

AID PROGRAM
S <input type="checkbox"/> SA
R <input type="checkbox"/> REFUGEE

AID CATEGORY
AA <input type="checkbox"/> AID TO THE AGED
AD <input type="checkbox"/> AID TO THE DISABLED
CID <input type="checkbox"/> CERTAIN DISABLED
RF <input type="checkbox"/> REFUGEE

CPPS
<u>ADOPTION ASSISTANCE</u>
CASH PAYMENT
IV - E <input type="checkbox"/>
IV - B <input type="checkbox"/>
STATE <input type="checkbox"/>
TYPE
TP <input type="checkbox"/> NR <input type="checkbox"/> mp <input type="checkbox"/>

OVERPAYMENT PERIOD					
FROM DATE			THRU DATE		

Cnty Contact Name _____ Ph# _____

REFUND AMOUNT	RECEIVED FROM _____ (Complete only if different than Casehead / Payee above)
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STATE OFFICE USE ONLY

FORMULA PERIOD						AMOUNT
FROM DATE			THRU DATE			

County Director's Signature _____

Date _____