VOLUNTARY WAGE WITHHOLDING AGREEMENT

Name: Medicaid PDC:

Address: Medicaid PLC:

I understand that I received $ _____ in Medicaid assistance that I was not entitled to receive for the period of _____ through _____. The balance currently due on this overpayment is $ _____.

I agree to allow $ _____ per (monthly, bi-weekly, weekly) to be withheld from my wages to repay the balance of $ _____. This voluntary wage withholding agreement will be in effect until my overpayment is paid in full. If I change my place of employment, I agree to repay the balance I owe by making (monthly, bi-weekly, weekly) cash payment in the amount of $ _____ until the balance of my overpayment is re-paid in full or to contact the Department of Social Services and report the name of my new employer so that this Voluntary Wage Withholding Agreement can be sent to them.

If I have any questions or problems making these payments, I understand I am to contact _____, of the Program Integrity Unit at telephone: ( ) _____.

I have entered into this agreement voluntarily and have not been threatened or coerced.

Beneficiary's Signature _____

Date _____

On behalf of the Select County Department of Social Services, I accept this repayment agreement.

Signature _____ Date _____

I certify that the responsible person named above personally appeared before me this day and acknowledged the due execution of this agreement.

Name _____ Title of Certifying Officer _____

Date _____ State and County _____

My commission expires _____