

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Division of Social Services**

**POST HEARING REPAYMENT NOTICE**

County: \_\_\_\_\_

Date: \_\_\_\_\_

Energy Application Number: \_\_\_\_\_

Referral ID: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dear \_\_\_\_\_:

The hearing conducted on \_\_\_\_\_ found that you received \$ \_\_\_\_\_ more Energy benefits than you were eligible to receive during the month of \_\_\_\_\_ in the year \_\_\_\_\_. Therefore, you must pay back the overissuance amount of Energy benefits you received.

If you 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 local office within 10 calendar days.

\_\_\_\_\_ 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 month on the \_\_\_\_\_ day of the month until such time as the claim is paid in full.

**Note:** The minimum payment cannot be less than \$25.00

**Note:** 1st payment is due within 15 days of the date of this notice.

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

If you have any questions, please call \_\_\_\_\_ at \_\_\_\_\_.

On behalf of \_\_\_\_\_ County, I accept this repayment agreement.

\_\_\_\_\_

County Representative

\_\_\_\_\_

Date

DSS-8658E (09/25)

Economic and Family Services