

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services
POST HEARING REPAYMENT NOTICE**

County: _____
Date: _____
Food and Nutrition Services Case Number: _____
Referral ID: _____

Name: _____
Address: _____

Dear _____:

The hearing conducted on _____ found that you received \$_____ more Food and Nutrition Services than you were eligible to receive during the month(s) of _____. Therefore, you and your household must pay back the value of the extra Food and Nutrition Services you received.

If you are actively receiving Food and Nutrition Services, the amount of benefits you receive each month will be reduced by 10% of the entitlement, or \$10.00, whichever is greater, for an administrative error or inadvertent household error claim; or, 20% of the entitlement, or \$20.00, whichever is greater, for an intentional program violation, until such time as the claim is paid in full.

If you are not actively receiving Food and Nutrition Services, 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 local office within 10 calendar days.

Your first payment is due 10 business days from the date of this notice.

Food and Nutrition Services claims must be paid in full within 36 months and monthly payments cannot be less than \$25.00.

To get the minimum monthly payment divide the amount owed by 36.

Contact your local **Food and Nutrition Services Office** if you have a hardship that would not allow you to make the required minimum monthly payment.

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.

Signature: _____

Date: _____

If you have any questions, please call _____ at _____

On behalf of _____ County, I accept this repayment agreement. _____

County Representative