

VOLUNTARY REPAYMENT AGREEMENT

County of _____
Department of Social Services

I, _____, case number _____, without being coerced, freely admit and fully understand that I have received public assistance/medical assistance/food stamps in the amount of \$_____ to which I was not entitled.

I agree to repay \$_____ each week/month until the full amount of \$_____ is repaid. Effectively date of the first payment is _____ and the full amount should be repaid by _____. If I fail to make regular payments and I am then receiving assistance, I understand my benefits will be reduced.

I agree to repay \$_____ each month by WFFA check deductions/FNS allotment reduction until the full amount of \$_____ is repaid. Should my income fluctuate, it could result in an allotment reduction change. I understand that amount taken then will be 10% of \$10.00 whichever is greater. Effective date of the first payment is _____ and this amount should be repaid by _____. If benefits are terminated, I agree to repay the remaining balance by cash.

I understand that the amount of Medical Assistance overpayment is subject to change due to all providers having 12 months from date of service to file claim for payment, and that, therefore, all claims may not have been paid yet. I agree to pay for any additional amount that may be added due to this reason. I understand I will be notified of any additional amounts.

Do not send cash through the mail. We will only accept a cashier's check, certified check, or money order. When paying in cash, bring in only correct change. Cash payments can be made to:

SEAL

Client Signature

Date: _____

Worker Signature

North Carolina
_____ County

I, _____, A Notary Public for said County and State, do hereby certify that _____ personally appeared before me this date and acknowledged the due execution of the foregoing instrument.

Witnessed my hand and official seal, this the _____ day of _____, ____.

OFFICIAL
SEAL

Notary Public

My commission expires: _____, ____