

AGREEMENT FOR VOLUNTARY FS REPAYMENT FROM FS EBT ACCOUNT

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS				
<div style="border: 1px solid black; width: 100%; height: 100%; margin: 0;"> <div style="border: 1px solid black; width: 100%; height: 100%; position: relative;"> </div> </div>		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____		
		OR Agency Conference _____		
		Record Access _____		
		Legal Assistance information _____		
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

Case Payee's SSN _____ - _____ - _____

Food Stamp Benefits Overpayment

You are currently receiving food stamps, and you were notified that you have a food stamp benefits overpayment and that your monthly food stamp benefits will be recouped (reduced) to pay back this overpayment. If you would **also** like us to take a one-time only additional amount from your food stamp benefits EBT account to pay back this overpayment, please fill out below:

I, _____, would like the agency to take:

- Everything in my EBT Food Stamp Benefits account, up to the amount of my overpayment(s).
- \$ _____ from my EBT Food Stamp Benefits Account, up to the amount of my overpayment(s).

I understand that this repayment from my EBT account is strictly voluntary.

Signature of Head of Household _____ **Date** _____

Your Address (if different than above): _____

Your Phone Number **Or** Where We Can Reach You (_____) _____.

If a phone number and/or address is in the box below, use this to contact us and to send back your Repayment Agreement. If the box is blank, use the phone number and address at the top of the page.

Accounting Use Only – FS Repayment 01

Date Entered on Admin Screen / / Transaction Amount \$, .

Entered by: _____

Date Verified / /