Attachment I

County of _____

Department of Social Services

Agreement of Voluntary Repayment

I, _____ have received a request for repayment of Medicaid benefits to which I was not entitled. I agree to repay the total amount of $_____ that was paid in error for the case _____.

[ ] I have enclosed a check (or money order) in the amount of $_____ to repay the total amount due.

[ ] I agree to repay the amount of $_____ each [ ] week [ ] month (choose one) until the total amount has been repaid.

[ ] I agree to a reduction in the amount of my future health insurance premium reimbursement payments by $_____ per month until the total amount has been repaid. **Please note that this repayment option is only available if you are currently eligible to receive health insurance premium reimbursement payments.**

I understand that if I do not agree to make the repayment, a court action to obtain the repayment may be taken. I also understand that my failure to agree to make a voluntary repayment will not affect my present or future Medicaid benefits. I agree to contact this office immediately if there is any change in my financial status. **I understand that I am not entitled to a fair hearing to review an agency decision to recover Medicaid overpayments.**

_____

Client Signature

_____

Date

Complete this agreement and please mail to:

_____

_____

Attachment II

[County Letterhead and Address]

Client Name: _____

Case Number: _____

Dear _____:

It has recently come to our attention that an incorrect payment of Medicaid benefits was made on your behalf under the above referenced case number. The amount of $_____ was paid in error for the time period of _____ to _____.

This amount is based on _____.

The reason for the overpayment is _____.

Enclosed with this letter is a Voluntary Repayment Agreement. Please read and sign the agreement and check the appropriate repayment box choice. If repayment will be made in weekly or monthly increments, please indicate which time period you would prefer and in what dollar amounts.

Forms of acceptable payment by mail include a check, a cashier's check, a certified check or money order. Checks or money orders should be made payable to:

_____

_____

Please mail the payments to the address listed above.

DO NOT SEND CASH THROUGH THE MAIL. Cash payments can be made in person at the address listed above to: _____.

Please be advised that if repayment arrangements are not made, a court action may be taken to obtain the amount due. **You are not entitled to a fair hearing to review an agency decision to recover Medicaid overpayments.**

If you have any questions, please contact _____ at_____.

Date: _____

Worker Signature: _____

Print Name: _____

Enclosure