Reset

South Carolina Department of Social Services
Family Independence (FI) and Supplemental Nutrition Assistance Program (SNAP)/Benefit Integrity

REPAYMENT AGREEMENT AND ACKNOWLEDGMENT OF DEBT

Case Name: _____ Case No: _____ County: Select County ...

Social Security Number (SSN): _____

Overpayment Amount:

Seq. Class

_____ _____ $ _____ in the Family Independence (FI) Program for the period of _____ to _____ .

_____ _____ $ _____ in the SNAP for the period of _____ to _____ .

_____ _____ $ _____ in the Supportive Services (SS) Program for the period of _____ to _____ .

I hereby acknowledge my debt owed to the South Carolina Department of Social Services (SCDSS) in the amount shown above. I agree to make payments in the manner indicated below:

If I currently receive benefits, I understand that my benefits are being reduced each month to repay my debt by

❑ 10% or $10, whichever is greater, for the _____ Program(s), effective _____ .

❑ 20% or $20, whichever is greater, for overpayments classified as intentional program violation for fraud in the SNAP Program, effective _____ .

I understand that this reduction will continue each month that I receive benefits until my debt (including other outstanding claim sequences in the same program) is paid in full. **I understand that if I stop receiving benefits before my debt is paid in full, I must make payments by one of the methods listed below.**

❑ I agree to increase the percentage by which my benefits are reduced each month to:

_____ % or $ _____ for SNAP, effective _____ .

_____ % or $ _____ for FI, effective _____ .

I understand that this reduction will continue each month that I receive benefits until my debt (including other outstanding claim sequences in the same program) is paid in full or until I terminate this agreement with the Benefit Integrity Claims Specialist. **I understand that if I stop receiving benefits before my debt is paid in full, I must make payments by one of the methods listed below.**

❑ I agree to make monthly payments by cash, money order or certified check in the amount of $ _____ beginning _____ (month) _____ (day) _____ (year) or effective the month of my case closure and continuing by the _____ of each month until debt is paid in full. I understand that these payments may be applied to any outstanding FI or SNAP debt for which I am responsible for payment.

I understand that I can repay my SNAP debt with benefits in my EBT account. I understand that using my EBT account as a method of payment is completely voluntary. I understand that this agreement to repay my debt by using benefits in my EBT account will remain valid until my outstanding SNAP debt is paid in full or until I terminate the agreement, whichever occurs first. **I understand that a request to end the process of monthly payments from my EBT account must be in writing and must be submitted to the Benefit Integrity Claims Specialist (BICS) for** Select County ... **County.**

❑ I agree to make a one time payment from my EBT account in the amount of $ _____ .

❑ I agree to make monthly payments from my EBT account in the amount of $ _____ .

I understand that SCDSS may use other collection methods to secure repayment of my debt and I hereby consent to the use of this Agreement as evidence against me for the repayment of my debt(s) above and any situation, including criminal and civil actions, relating to and/or involving the amounts owed. I also understand SCDSS may authorize the Internal Revenue Service (IRS) and/or the South Carolina Department of Revenue, and/or SC Education Lottery to withhold any refund due to me to repay my debt if I do not make payments as scheduled above.

I understand that this agreement does not preclude criminal prosecution or civil action, even if all outstanding balances are paid, if it is determined that I have committed an intentional program violation classified under state and federal statutes as fraud.

Signature of Debtor: _____ Date: _____

Signature of BICS: _____ Date: _____