INVESTIGATION, REVENUE AND ENFORCEMENT ADMINISTRATION

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INFORMATIONAL 2016-07-IREA

(Replaces INF-2014-16-IREA)

IREA SETTLEMENT NEGOTIATION UPDATE

Audience	Bureau of Fraud Investigation and Claims and Collections Investigators.
Purpose	This is to inform all Investigators of the policy relating to client negotiations for repayment of Cash Assistance (CA), Supplemental Nutrition Assistance Program (SNAP) or Medicaid (MA) benefits.
Background	When HRA has established a claim because a client has received an overpayment of benefits, in some situations, the claim amount may be negotiated with the client. This Informational explains the policy for negotiating a reduced claim. When the amount is agreed upon, the Investigator completes the <u>Settlement Agreement Form - BFI-201</u> for HRA. The client completes the form by signing it.





Use of EBT Account Credit As Partial or Full Repayment of Debt Clients may make extra voluntary payments to reduce overpayment claim amounts at any time. Clients with active cases have the option of requesting in writing that SNAP benefits in their EBT account be used as partial or full repayment of their debt or by using form LDSS-4053 "Supplemental Nutrition Assistance Program (SNAP) Benefits Compromise/Repayment Agreement Request," Attachment 1, to do the same.



Attachment 1

Supplemental Nutrition Assistance Program (SNAP) Benefits Compromise/Repayment Agreement Request (LDSS-4053) (page 1 of 2)

		OMPROMIS		ANCE PROGRAM (S T AGREEMENT REC	UEST
OTICE DATE:				NAME AND ADDRESS OF AGEN	CY/CENTER OR DISTRICT OFFICE
ASE NUMBER		CIN NUMBE	ER	-	
			-		
CASE	NAME (And C/O Nar	me if Present) AND /	NDORESS		
Г				GENERAL PHONE NO. FOR QUESTIONS OR HELP	
I			I	OR Agency Conference	
1			I.	Record Access	
				Legal Assistance Inform	ation
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NA	ME	PHONE NO.
Case Payee's	SSN				
You were alrea	dy notified that	you had a SN/	AP overpayment(s)) due to the reason(s) belo	DW.
					ntional Program Violation (IPV)
	nefits Case is n	ow closing or i	s closed. You mu	st repay this overpayme	ent per 18 NYCRR 387.19.
You must:	nis Repayment				
		-			
	the X below an				
			will be referred for		days from the date of this notice or
					the of each month or
					e done each month until your debt is
paid, or	r you will be del	linquent and yo	our debt will be refe	erred for collection.	
					llow a compromise, the amount you
must repay may Acknowledgme			ount will be in the	SNAP Benefits Comprom	ise/Repayment Agreement
-		-			
					and a supplicity of the suppli
full amount	ay are monany .	amount above	, write down what y	you can pay per month ar	d explain why you cannot pay the
full amount:					nd explain why you cannot pay the
full amount:			because_		id explain why you cannot pay the
full amount: I will make a c	one time only pa	ayment of \$		r	nd explain why you cannot pay the
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Supplemental Nutrition Assistance Program (SNAP) Benefits Compromise/Repayment Agreement Request (LDSS-4053) (page 2 of 2)

Name:	Address:	Case Number:
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