# INVESTIGATION, REVENUE AND ENFORCEMENT ADMINISTRATION

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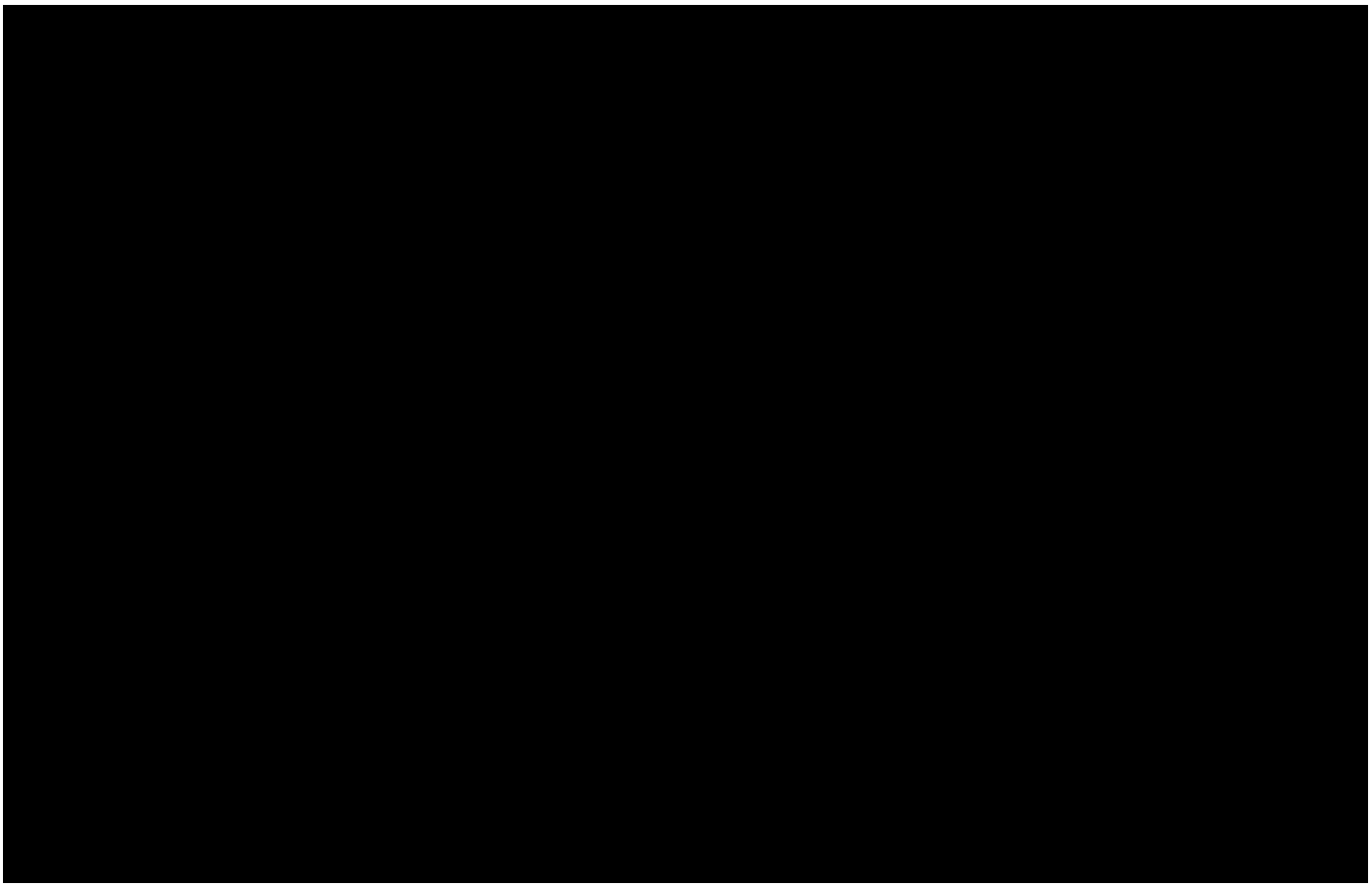
*(Replaces INF-2014-16-IREA)*

## 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 *Settlement Agreement Form* - BFI-201 for HRA. The client completes the form by signing it.



[redacted]

**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.

[redacted]

## Attachment 1

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

**LDSS-4053** (Rev. 08/12) AE/IHE/IPV Closing/Closed Cases - SNAP

**SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS COMPROMISE/REPAYMENT AGREEMENT REQUEST**

| 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 | | GENERAL PHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Record Access _____<br>Legal Assistance Information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | PHONE NO. |
|---|---|---|---|---|
| | | | | |

Case Payee's SSN _____ - _____ - _____

You were already notified that you had a SNAP overpayment(s) due to the reason(s) below.

☐ Agency Error (AE) ☐ Inadvertent Household Error (IHE) ☐ Intentional Program Violation (IPV)

Your SNAP benefits Case is now closing or is closed. **You must repay this overpayment per 18 NYCRR 387.19.**

You must:

- ☑ Read this Repayment Agreement
- ☑ Sign at the **X** below and date it
- ☑ Return it with your first monthly payment of $_____ within the next thirty (30) days from the date of this notice or you will be delinquent and your debt will be referred for collection.
- ☑ Continue to send the monthly/other payment so that the payment reaches us by the _____ of each month or $_____on ____ and ____ if the payment schedule is bi-weekly. This must be done each month until your debt is paid, or you will be delinquent and your debt will be referred for collection.

Local Districts are permitted to Compromise on the amount of the debt you owe. If we allow a compromise, the amount you must repay may be reduced and the new amount will be in the SNAP Benefits Compromise/Repayment Agreement Acknowledgment that we will send to you.

If you cannot pay the monthly amount above, write down what you can pay per month and explain why you cannot pay the full amount:

I will make a one time only payment of $_____ because_____.

**or**

I can only pay $ _____ per month/other because _____.

If you have SNAP benefits in your EBT account that you would like the agency to take back as partial or full repayment of your debt, please fill out the box below and also sign below:

☐ EBT Account – I want the local social services district to take everything in my EBT SNAP benefits account, up to the total amount of my overpayment(s). I understand that if there is not enough in my EBT SNAP benefits account to pay back my overpayment(s), I must also explain above how I will repay the rest.

Your Address (if different than above) is: _____.

Your Phone Number **or** Where we can reach you (_____)_____.

**Signature** of head of household **X**_____ Date _____

We will contact you to discuss the repayment method you have chosen and give you a written statement showing how much you will be repaying (and how long your payments will continue should you choose to repay through monthly payments.)

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

**RETURN THIS FORM TO US RIGHT AWAY**

**WARNING**: IF YOU DO NOT RETURN THIS SNAP COMPROMISE/ REPAYMENT AGREEMENT REQUEST, YOU WILL BE SUBJECT TO AUTOMATIC COLLECTION. SEE THE BACK OF THIS NOTICE FOR MORE INFORMATION ON AUTOMATIC COLLECTION.

If your household's financial circumstances change, you may contact us at the phone number above to try to renegotiate your SNAP Compromise/Repayment Agreement Request. If you have any questions, please call us at the number above.

**Accounting Use Only – SNAP Repayment 01 –** ***(Completed by worker after agreement is accepted)***

Repayment Agreement Date _____

Repayment Amount $ _____ Per _____ (frequency)

Recurring Payment Due Date _____

Was a Claim Compromised? ☐ No ☐ Yes, from $ _____ to _____ Claim No: _____

Date Entered on Admin. Screen _____/_____/_____ Transaction Amount $ ____ . _____ . ____

Entered By : _____ Date Verified _____/_____/_____

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

LDSS-4053 (Rev. 8/12) AE/IHE/IPV Active/Closing/Closed Cases – SNAP

**SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS COMPROMISE/REPAYMENT AGREEMENT REQUEST**

| Name: | Address: | Case Number: |
|---|---|---|
| | | |

## Warning!

Even if you are no longer getting SNAP benefits, you must repay us, according to 18 NYCRR 387.19.

If you fail to sign and return this agreement or fail to make your required payments on time, you will be delinquent and this overpayment will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges. Also, if you get restored benefits or new SNAP benefits in the future, we will reduce those benefits to pay back this overpayment. This is based on 31 CFR 285.

Your local district will consider your request for SNAP Benefits Compromise and/or Repayment Agreement terms only once for your claim.

You will receive a SNAP Benefits Compromise/Repayment Agreement Acknowledgment informing you of the districts decision on your request.