DSS-OS-954 03/09

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
CLIENT AUTHORIZED DEBIT FOR REPAYMENT OF OVERISSUANCE

CASE NAME: _____ SSN: _____

CASE NUMBER: _____ BENEFITS SPECIALIST: _____

( ) I voluntarily choose to have $_____ of SNAP benefits debited from my EBT account to repay a previous overissuance of SNAP benefits.

( ) I want to repay $_____ for _____ month(s) until the debt is paid in full.

( ) This is a verbal authorization to debit my EBT account in the amount of $_____. (Indicate below who took the verbal authorization).

I understand that in order to repay the overissuance, multiple debits may need to be completed against my EBT account in order to recover the full amount. I also understand that I may revoke this agreement at any time.

_____ _____
Head-of-Household/Authorized Representative Signature Date

_____ _____
Witness Signature Date

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ORFI DEBIT TRANSACTION REQUEST

The Office of Recoveries and Fraud Investigations has received a client request for repayment. The claim/payment screens have been reviewed to support this debit.

DEBIT AMOUNT $_____.

( ) This amount is equal to the amount the client requested.

( ) This amount is less than the amount the client requested due to the remaining balance of the claim at the time of the request.

_____ _____
Recoveries Signature Date

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EBT DEBIT TRANSACTION NOTICE

( ) This request has been approved and the transaction completed. The above client's EBT benefit account has been debited in the amount of $_____.

( ) This request has been denied. The federal SNAP account balance was not sufficient to allow the transaction.

_____ _____
EBT State Office Signature Date

Original - ORFI case file
Copy - EBT State Office