

**CALWORKS REQUEST FOR VOLUNTARY REPAYMENT**

Case Name \_\_\_\_\_ Case Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_

On \_\_\_\_\_, you were told that you were overpaid California Work Opportunity And Responsibility to Kids (CalWORKs) benefits:

All or part of the CalWORKs payment you got for the month(s) of \_\_\_\_\_ to \_\_\_\_\_ is an overpayment. You are getting this form because all of the following apply:

- You got this form after an explanation by the County of the overpayment; and
- The County did not ask you to make voluntary payments; but, you asked to make voluntary payments.
- You may volunteer to repay all or part of the overpayment. The amount of the overpayment is \$ \_\_\_\_\_. You are making a  one-time  monthly (check one) voluntary repayment of \$ \_\_\_\_\_. Repayment method:  Check  Cash  EBT. You can stop your voluntary payments at any time. If you decide to stop your voluntary payments, the county can collect the rest of your overpayment.

If you agree to this voluntary repayment, you may send a check or money order to the address listed below. Please include your case number on your check or money order. Payments should be mailed to:

County Contact Name:  
County Department/District office:  
Address:  
City, State and Zip Code:

**OR**

If you want money taken directly out of your EBT account at one time, please enter the amount you would like taken out of your CalWORKs EBT account and sign and date below .

\$ \_\_\_\_\_ Amount \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

EBT card number: \_\_\_\_\_ Overpayment claim number: \_\_\_\_\_

By signing this form, I understand that I am authorizing the County to deduct funds from my EBT account to repay my overpayment. I certify that I am the EBT cardholder on this account. I understand that as an EBT cardholder I have the authority to authorize payment from this account in order to make a payment on an overpayment. I understand that repayment of an overpayment using EBT account funds is a voluntary action and I am giving my consent to use CalWORKs benefits from this account to repay overpaid benefits. I understand that this agreement may be altered or terminated at any point in the future at my request. If you have any questions about how the overpayment was figured or about repayment arrangements, please call:

\_\_\_\_\_ at \_\_\_\_\_  
Worker Name Worker Phone Number

**County Only Section**

Benefits withdrawn from Cash EBT account for cash overpayment:

Claim: \_\_\_\_\_ in the amount of \$ \_\_\_\_\_.

Worker name: \_\_\_\_\_

Worker signature: \_\_\_\_\_

Worker number: \_\_\_\_\_

Date: \_\_\_\_\_