Reset Form

NOTICE OF MEDICAID OVERPAYMENT

Name	Case Name		
Street Address	Case Number		
City, State and Zip Code	County	Date Sent by CDJFS	Date Rec'd by CDJFS

Section I: Overpayment

(all checked boxes apply to you)

After carefully reviewing the above Medicaid assistance group records, we have determined that from _____ to _____ the assistance group received $ _____ more in medical services paid by Medicaid than the assistance group was eligible to receive. You are responsible for repayment of the amount overpaid.

REASONS FOR OVERPAYMENT

The reasons for the overpayment and the specific regulations supporting the overpayment determination are: _____

_____

☐ The reason indicated above is a result of your error

☐ The reason indicated above is a result of the error of someone acting in your behalf

Section II: Your Responsibility

You are responsible for repayment of the overpayment. You may repay the overpayment by choosing one of the repayment arrangements listed in Section III.

If you do not return this form with your choice of a repayment arrangement within 30 days from the date the form was sent by the CDJFS, we may take legal action against you to recover the overpayment.

If you choose a repayment agreement and then find that the repayment is difficult or impossible, contact the CDJFS. We will review your present financial situation with you. If you and the CDJFS cannot agree upon a revised or new payment agreement. you may stop repayment under your present repayment arrangement, but you are still responsible for repayment of the overpayment. We may take legal action against you to recover the overpayment.

Section III: Repayment Arrangements

You may choose from the repayment arrangements below:

☐ LUMP-SUM REPAYMENT - The entire overpayment repaid in one payment within 60 days from the date this form was sent by the CDJFS. If you repay part of the overpayment in a lump sum, you may repay the rest of the overpayment in monthly payments by completing the following Monthly Recovery Agreement Section.

If you agree to make the entire payment within 60 days, complete and sign your name below and return this form.

I agree to repay the entire overpayment in one lump-sum payment within 60 days.		
Signature	Date	Telephone Number

☐ MONTHLY RECOVERY AGREEMENT - You agree to make an initial payment at once and the balance in monthly payments or repay the entire overpayment in monthly payments until the overpayment is repaid.

If you choose to repay the overpayment in monthly payments, complete and sign your name below and return this form. If you and the CDJFS cannot agree upon the terms of a separate monthly recovery agreement, you are not bound by signing this form. If you wish to discuss terms, please contact the person listed below. You do remain responsible for payment of the overpayment and we may take legal action against you to recover the overpayment.

I agree to repay $ _____ no later than (date) _____ , and to pay $ _____ in monthly payments beginning (date) _____ .

Signature	Date	Telephone Number

INSTRUCTIONS

If you have agreed to repay the overpayment by choosing one of the repayment arrangements, return one completed form to the county department of job & family services at the address at the bottom of the form. Keep the other completed form for your records.

YOU HAVE A RIGHT TO A STATE HEARING

If you do not agree with this proposed action, you have the right to a state hearing. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against this decision. The county department of job & family services will also attend the hearing to present its reasons. A hearing officer from the Ohio Department of Job & Family Services will decide whether you or the county department of job & family services is right. If you win your hearing, the decision may not be implemented. If you lose your hearing, you may have to pay back benefits that you received but were not eligible to receive. If you want a hearing, we must receive your hearing request within 90 days of the mailing date of this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free, at 1-800-589-5888.

If you want a state hearing, all you have to do is sign your name below, and date, and send this form to the Ohio Department of Job & Family Services, Bureau of State Hearings, 30 East Broad Street, 32nd Floor, Columbus, Ohio 43266-0423.

I request a State Hearing		
Signature	Date	Telephone Number

Signature of County Department of Job & Family Services Representative	Date	Telephone Number
County Department of Job & Family Services	Address	

Distribution: Original and one copy to party responsible for overpayment; one copy for case file.