M834 MA NOTICE OF REPAYMENT

It has been determined that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

received medical assistance for which they were not eligible. The

overpayment is due to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and was the result of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

They were not eligible for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ which was received in the

period \_\_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The amount owed must be repaid.

Complete the agreement below and return it by \_\_\_\_\_\_\_\_\_\_\_\_\_.

 \_\_\_\_\_ I agree to repay DCF in one lump sum payment in the following manner:

 \_\_\_\_\_\_Payment is enclosed, or

 \_\_\_\_\_ payment will be made by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 \_\_\_\_\_ I cannot repay DCF in one lump sum. I agree to a special

 spenddown to repay this overpayment. Medical expenses may be

 counted against this special spenddown if

 1) the expense is verified;

 2) it is for a medically necessary service (As determined by DCF);

 3)I report the verified expense to DCF within 6 months from the date of service.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE DATE

Do not send cash through the mail. Send payments by check or money

 order to: DCF Central Cashier, Docking State Office Building, Topeka,

 KS 66612, or you may bring cash to the local office. Checks and money

 orders should be made payable to: "State Department for Children and Families”

This is based on the KEESM Sections 11121 and 11124.