



Overpayment Claim

Form H1018
March 2009

To: _____

From: _____

| | | | | | |
|---|---------------------------|-------------|--------------------------------------|-----------|----------|
| Reason for Report: <input type="checkbox"/> New Claim <input type="checkbox"/> Modification of Existing Claim: | | | ARTS Claim No. (if assigned) | | |
| Investigation No. | Investigator Employee No. | Region/Div. | Investigator Telephone No. () | Mail Code | Unit No. |

Primary Liable Client Information

| | | | | | | |
|---|-------|------------|---|---------------|-----|-------------------------|
| Name—Last or Business Name | | | First | | MI | Suffix |
| Social Security No. | | Client No. | | Date of Birth | | Overissuance County No. |
| Street Address—Line 1 | | | Mailing Address (if different)—Line 1 | | | |
| Line 2 | | | Line 2 | | | |
| City | State | ZIP | City | State | ZIP | |
| Group Members: <input type="checkbox"/> Default to SAVERR/TIERS Group Membership | | | To identify additional group members complete the group members section on Page 2 of this form. | | | |

Claim Information

| Claim Category <input type="checkbox"/> Recipient <input type="checkbox"/> Provider | TANF | Food Stamps | Medicaid | CHIP/SKIP | Other: _____ | WIC |
|--|---|---|---|---|---|---|
| SAVERR Case/EDG No. | | | | | | |
| Personal Account No. | | | | | | |
| Client ID No. | | | | | | |
| Family ID No. | | | | | | |
| OIG Disp. Code/Claim Type | | | | | | |
| Overissuance Begin Date | | | | | | |
| Overissuance End Date | | | | | | |
| Total Amount Owed | | | | | | |
| Amount to be Recovered | | | | | | |
| Collection Recovery Effort | <input type="checkbox"/> Pursue <input type="checkbox"/> Suspend | <input type="checkbox"/> Pursue <input type="checkbox"/> Suspend | <input type="checkbox"/> Pursue <input type="checkbox"/> Suspend | <input type="checkbox"/> Pursue <input type="checkbox"/> Suspend | <input type="checkbox"/> Pursue <input type="checkbox"/> Suspend | <input type="checkbox"/> Pursue <input type="checkbox"/> Suspend |
| Uncollectible Amount | | | | | | |

Payment Plan: The payment schedule, amount and frequency can be determined by ARTS; check the method of recovery below for each program area.

| | | | | | | |
|---|-------------------------------------|--------------------------------------|-------------------------------------|--------------------------------------|----------------------------------|------------|
| Method of Recovery | TANF | Food Stamp | Food Stamp | Restitution for | Debit to EBT | Begin Date |
| <input type="checkbox"/> TANF Restitution | <input type="checkbox"/> Recoupment | <input type="checkbox"/> Restitution | <input type="checkbox"/> Recoupment | <input type="checkbox"/> Other Claim | <input type="checkbox"/> Account | |

Probation Information

| | | | | | |
|----------------------|--------------------|----------------------|---------------------|------------------|----------------|
| Probation Begin Date | Probation End Date | Probation County No. | Probation Cause No. | Total Amount Due | Payment Amount |
|----------------------|--------------------|----------------------|---------------------|------------------|----------------|

| | | |
|-----------------------------------|------|-------------|
| Offset Payments | TANF | Food Stamps |
| <input type="checkbox"/> Restored | | |

| | | |
|-------------|--------------|-----------|
| Worker Name | Employee No. | Mail Code |
|-------------|--------------|-----------|

Signature _____

Date _____

Investigation No.

Overpayment Claim (Supplement)

Additional Group Members – In order of liability

| | | | | | |
|---------------------------|-------|-----|---------------------------------------|------------|---------------|
| 2. Name (Last, First, MI) | | | Social Security No. | Client No. | Date of Birth |
| Street Address–Line 1 | | | Mailing Address (if different)–Line 1 | | |
| Line 2 | | | Line 2 | | |
| City | State | ZIP | City | State | ZIP |

| | | | | | |
|---------------------------|-------|-----|---------------------------------------|------------|---------------|
| 3. Name (Last, First, MI) | | | Social Security No. | Client No. | Date of Birth |
| Street Address–Line 1 | | | Mailing Address (if different)–Line 1 | | |
| Line 2 | | | Line 2 | | |
| City | State | ZIP | City | State | ZIP |

| | | | | | |
|---------------------------|-------|-----|---------------------------------------|------------|---------------|
| 4. Name (Last, First, MI) | | | Social Security No. | Client No. | Date of Birth |
| Street Address–Line 1 | | | Mailing Address (if different)–Line 1 | | |
| Line 2 | | | Line 2 | | |
| City | State | ZIP | City | State | ZIP |

| | | | | | |
|---------------------------|-------|-----|---------------------------------------|------------|---------------|
| 5. Name (Last, First, MI) | | | Social Security No. | Client No. | Date of Birth |
| Street Address–Line 1 | | | Mailing Address (if different)–Line 1 | | |
| Line 2 | | | Line 2 | | |
| City | State | ZIP | City | State | ZIP |

| | | | | | |
|---------------------------|-------|-----|---------------------------------------|------------|---------------|
| 6. Name (Last, First, MI) | | | Social Security No. | Client No. | Date of Birth |
| Street Address–Line 1 | | | Mailing Address (if different)–Line 1 | | |
| Line 2 | | | Line 2 | | |
| City | State | ZIP | City | State | ZIP |