Iowa Department of Human Services

EBT ADJUSTMENT REQUEST

Name	State ID #
Case Number	Date of Claim

Debit Reason (Include amount and date entry made to ABC or EPPIC):

☐ Claims payment * Amount:

☐ Voluntary termination Amount:

☐ Death Amount:

☐ Other Amount: Date:

Explain:

The amount to be debited must be available in the EBT account for the adjustment to occur.

Client Name	Date
Worker Name	Worker Number
Phone Number	County Number

CENTRAL OFFICE USE ONLY

☐ Claim processed:

☐ EBT adjustment completed: $ Date completed:

☐ EBT adjustment not completed because:

Name	Date

Send to Purchasing, Payments & Receipts (Attn: Cashier)

* For claims payment, enter date of claim and also send a copy of *Overpayment Recovery Information Input*, form 470-0464.