IOWA HHS

Iowa Department of Health and Human Services

Notice of SNAP Debt

Keep This Part

Date: Account Number:

If you have questions about this notice, call **1-800-572-3945** (toll free).

You were found guilty of trafficking or misuse of SNAP benefits and ordered to pay the Iowa Department of Health and Human Services (HHS) $ for the months of: to

What You Need to Do

Step 1: Choose a Payment Plan

If a payment was set by a court you must pay that amount.

If a court did not set your payments, you can choose one of the following:

Plan 1. Pay the full amount in one payment.

Plan 2. Make monthly payments.*

Plan 3. Pay part of what you owe now and pay the rest in monthly payments.*

Plan 4. Have HHS take benefits from your EBT account now. (If this does not pay all of the claim, choose an additional plan to pay the rest.) Note: You may make monthly payments from your EBT account, but additional information will be needed in writing. Call Iowa Department of Inspections, Appeals and Licensing (DIAL) for instructions on what information must be included in your request.

Plan 5. Have HHS keep part of your monthly benefits if you get SNAP now.

- If you get SNAP benefits, your monthly payments must be more than $20 or 20% of your monthly SNAP benefit, whichever is higher.
- If you do not get SNAP benefits, your monthly payments cannot be less than $50 or the amount you owe divided by 36 months, whichever is more. **NOTE:** If you are not able to pay this amount each month, call DIAL at 1-800-572-3945 to discuss other payment options.

Step 2: Fill Out and Mail the Agreement to Pay – Remember to:

- Fill in all the blanks.
- Choose a payment plan.
- Sign and date the form.
- Return the Agreement to Pay within 20 days of the date of this letter.

Mail the form to:
DIAL
Public Assistance Debt Recovery Unit
6200 Park Ave, Suite 100
Des Moines, IA 50321-1371

If you choose Plan 1, 2, or 3, you will get a bill with instructions on how to make payments. If your household's income changes, you can ask us to change your agreement.

Actions to Collect the Debt

FEDERAL RULES REQUIRE THAT HHS ESTABLISH ALL OVERPAYMENTS. Collection may be made from all adults who were members of your household at the time of the overpayment.
You were previously ordered to pay this debt per a final administrative hearing decision, or as restitution ordered by a local, state, or federal court. The debt has been referred to the Iowa Department of Inspections, Appeals and Licensing (DIAL) for collection. DIAL will collect on this debt by doing one or more of the following:

- Keep part of your monthly benefit if you get SNAP, or
- Bill you for the debt.
- If you do not return an Agreement to pay or you are past due on your account:
  - Take money that is owed to you by any state agency. For example, all or part of your state income tax refund, lottery winnings or state wages, or
  - Take your federal tax refund, part of your Social Security benefit, or part of your pay if you work for the federal government*, or
- File a civil suit to collect the overpayment, or
- Refer your case for prosecution (if we have reason to believe that you intentionally withheld or gave false information in order to get benefits you were not entitled to).

* You can stop this action if you make an acceptable written agreement to repay your debt and you are not past due on your account before the debt is referred to the Department of Treasury. If you fail to make a written agreement and your claim is referred to the Department of Treasury, you must pay additional processing charges when the collection is made. Your HHS worker will let you look at the case record and give you a copy of the overpayment calculation if you request it.

You Have the Right to Appeal An appeal is a request for a hearing regarding a decision made by the Iowa Department of Health and Human Services (HHS). You have the right to file an appeal if you disagree with a decision. You don't have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].
You can appeal in person, by phone, or in writing for SNAP. To appeal in writing, you must do one of the following:

- Complete an appeal electronically at https://hhs.iowa.gov/programs/appeals, or
- Write a letter telling us why you think a decision is wrong, or
- Fill out an Appeal and Request for Hearing form. You can get this form at your county HHS office.

Send or take your appeal to HHS, Appeals Section, 321 E. 12th St., Des Moines, IA 50319-1002. If you need help filing an appeal, ask your county HHS office. You or someone else, such as a friend or relative, can tell why you disagree with the HHS decision. You may also have a lawyer help you, but HHS will not pay for one. Your county HHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

How long do I have to appeal? For SNAP you have 90 calendar days from the date of a decision to file an appeal. If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending? You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal within 10 calendar days of the date the notice is received. A notice is considered to be received 5 calendar days after the date on the notice. Any benefits you get while your appeal is being decided may have to be paid back if the HHS action is correct.

How will I know if I get a hearing? You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Request to Reduce or Settle a Claim

You have the right to ask the Iowa Department of Health and Human Services (HHS) not to collect some or all of your overpayment. We may reduce any part or all of the claim if we believe you are not able to repay the claim.

If you want to ask us to lower part or all of your overpayment, write us a letter telling us:

- Your mailing address,
- A phone number where we can reach you or leave a message for you,
- Your social security number, and
- Why you cannot pay part or all of your overpayment.

Mail the letter to: HHS, Appeals Section, 321 E. 12th St., Des Moines, IA 50319-1002.

When you ask us to lower part or all of the amount you owe, we will look at things like:

- How much you owe,
- When (the date) the overpayment happened, and
- Things that make it hard for you to pay, like financial hardship or other unusual problems.

We may then agree to settle, adjust, compromise or deny part or all of the overpayment. In other words we may agree that you don't have to pay back any of the overpayment or that you only have to pay back part of it.
NOTE: If your family's income changes, you can ask to change your repayment agreement to lower the amount you pay.

You Will Not Be Discriminated Against It is the policy of the Iowa Department of Health and Human Services (HHS) to provide equal treatment in employment and provision of services to applicants, employees, and clients without regard to race, color, national origin, sex, sexual orientation, religion, age, disability, political belief or veteran status. If you feel HHS has discriminated against or harassed you, please send a letter detailing your complaint to: HHS, Bureau of Human Resources, 321 E. 12th St., Des Moines, IA 50319-1002 or via email FDHS@hhs.iowa.gov

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g. Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf , from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or

2. **fax:**
   (833) 256-1665 or (202) 690-7442; or

3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Agreement to Pay

Due Date:

Mail This Part

Case Name: Account Number:

I, _____, agree to pay HHS.
(First Name, Middle Initial, and Last Name)

If a court ordered payment, you must pay that amount.

If you do not have a court ordered payment amount, check one of the plans below:

___ Plan 1: Pay the full amount in one payment.

___ Plan 2: Make monthly payments of $_____ per month.
Starting date: _____.

___ Plan 3: Pay $_____ now and pay the rest in monthly payments of $_____ per month.

___ Plan 4. Have HHS take benefits from my EBT account now. (If this does not pay all of the claim, choose an additional plan to pay the rest.) Note: You may make monthly payments from your EBT account, but additional information will be needed in writing. Call DIAL for instructions on what information must be included in your request.

___ Plan 5: Having HHS keep $20 or 20% of my monthly SNAP benefits, whichever is more.

By signing this agreement, I understand that:

- If I get SNAP benefits, my monthly payments must be more than $20 or 20% of my monthly SNAP benefit, whichever is higher.
- If I do not get SNAP benefits, my monthly payments cannot be less than $50 or the amount I owe divided by 36 months, whichever is more. If DIAL agreed to a different amount, I understand I need to pay that amount.
- I can pay the balance off at any time.
- If I sign this agreement and do not follow its terms, it will break the contract and other action may be taken against me.

Signature	Phone	Date

For Office Use Only:

Signed: Date: Title: