



Child Care Assistance Application Checklist

✓ Check to be sure you have submitted the following documents. To reduce processing time and avoid delays please be sure all applicable items listed below are submitted with the completed application.

- The completed and signed application. Parent and spouse or both parents in the family must sign the application.
- A copy of your government issued photo identification (for each parent or spouse on the application).
 - My photo ID is on file with the CCA office.
 - Other parent/spouse's photo ID is on file with the CCA office.
- Proof of age for each child who will be receiving child care. (This can be copies of birth certificates, hospital birth records, shot records)
 - Age verification is on file with the CCA office for all children needing child care assistance.
- Proof of alien status for each child who will be receiving child care assistance, if not a U.S. citizen.
 - Alien status verification is on file with the CCA office for all children needing child care assistance.
- Proof of child custody, if applicable. (This can be court order, affidavit or statement)
 - Current court documents are on file with the CCA office for all children needing child care assistance.

Eligible activity for each parent or spouse on the application:

- A copy of your current and/or future school schedule showing classes you are registered to attend with the school name or school name and hours if attending high school.
- Proof of current and/or future financial aid / account summary by term, for money received for college.

Earned income for each parent and or spouse on the application:

- Proof of all earned income received by each parent/spouse on the application. (This can be your most recent paystubs or employment verification letter or verbal statement from your employer)

Unearned income for ALL members of your family:

- Proof of unearned income for all members of your family. Unearned income includes but is not limited to: dividends and interest, payments from Child Support, Social Security, Supplemental Security Income (SSI) and Native Corporations. Please refer to unearned income section on page 3 of the Application.
- For self-employed individuals only: a copy of your current business license and/or professional license, fishing permit/card, your most recently completed Federal tax return with schedule C, or income and expense records or other documentation of adjusted gross income and allowable costs of doing business. Three months of income and expense records are preferred to make a more accurate determination.

Possible deductions:

- Proof of ongoing medical or dental payments, if applicable. See page 3 of application.
- Proof of child support you are legally obligated to pay and are paying, if applicable.

Return the completed application with all documents to:

DHHS, Child Care Assistance Program
825 L Street, Ste 215
Anchorage, AK 99501

Child Care Assistance Program General Information

Who do I contact if I need help filling out the application or have questions?

If you have questions or need assistance in completing your application, please contact your local Child Care Assistance Office (noted in the bottom right corner of the previous page).

When do benefits begin if I am determined eligible?

If eligible, benefits will begin the date you submitted your signed application as long as all the required documentation is received within 30 days. Benefits cannot be backdated. Avoid possible delays or lapses in service by submitting all the required documentation with your application.

Is an interview required?

Yes. An interview is required at least once a year before it can be determined if you are eligible for assistance. Your interview may be in person or by telephone. Your application will be denied if you do not complete an interview.

Once I am determined eligible, what do I need to do to maintain my eligibility?

You must notify your Child Care Assistance office of any changes in your income and/or family within 10 days of when the change occurred. You must also submit a new application with all the required documentation and complete an interview before your eligibility expires, at least annually.

Will I have to pay anything?

Yes. You will have a monthly family contribution amount depending on your income and family size. This is called a co-pay. Your provider may also charge rates that are more than the assistance program pays. Each month you will have to pay your provider the co-pay amount and the difference, if any, between what the provider charges and what the state pays.

Which child care provider(s) can I use?

Child care providers must also apply to participate in the Child Care Assistance program. A provider cannot receive State funding until they are approved or licensed. You may use any participating provider that has space and can meet your child care needs. You may also select a person to come into your home to care for your children. Having someone come into your home requires you to meet additional employer requirements. The Child Care Resource and Referral agency that serves your community can help you get a list of participating providers in your area. The Child Care Resource and Referral agency can also help determine if your child qualifies for additional resources due to having a special need (See 7 AAC 57.940 Children with special needs).

Who is considered part of my family?

The following descriptions of family are for Child Care Assistance purposes only.

- To be considered part of your family, ***all members must live in the same home.***
- Of the people living in your home, your family includes: ***yourself, your spouse and each of your children who are under 18 years of age.***
- If you have adult children (18 and older) living in your home, do not include them on this application.
- You may also have children living in your home who are not biologically yours. ***If you are their guardian and have financial responsibility for them,*** they are counted as part of your family.
- If you are not married, but ***the other parent of any of your children lives in your home,*** he or she and his or her children are considered part of your family.
- If you are not married but are living in the same home with another adult who has children of their own, and you have no children in common, he or she and his or her children are not considered part of your family. In this case each parent may apply to receive Child Care Assistance for their own children.
- If you are 18 or older and living with your parent(s) and/or other adult siblings or relatives, your parent(s), siblings and relatives are not considered part of your family and are not included on this application.



State of Alaska
 Department of Health and Social Services
 Division of Public Assistance
 Child Care Program Office
<http://www.hss.state.ak.us/dpa/programs/ccare/>

For Office Use Only	
Date Received	
N	R
Benefit Start:	
Cert. Period:	

PLEASE PRINT CLEARLY USING BLACK OR BLUE INK

Who is the Responsible Party? This is the person who is requesting Child Care Assistance and assumes responsibility for compliance with program rules and requirements, including penalties and repayment of any overpaid benefits.			
Full Name of Responsible Party (First, Middle, Last)		Maiden Name, if any	Social Security Number (Optional)
Home Address		City	State AK
Mailing Address		City	State AK
Home Telephone	Work Telephone(s)	Cell Telephone(s)	E-mail
Marital Status		Other Names You Have Used	

Who is Considered Part of My Family? List each person in your family starting with yourself. See definition of family on Page 2 of the application checklist. You will need to provide a copy of the alien identification card (front and back) for each child who is not a U.S. citizen. If more space is needed, you may use a separate sheet or Page 6 of this application.							
Family Members (First, Middle, Last)	Relationship to you	Date of Birth mm/dd/yyyy	Social Security Number (optional)	Special Needs (as defined by 7AAC 57.940)	Gender U.S. Citizen	Ethnicity (Use codes below)	Race (Use codes below)
	SELF			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> AN <input type="checkbox"/> AI <input type="checkbox"/> AS <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> PI
Ethnicity: Y = Hispanic or Latino N = Not Hispanic or Latino		Race (you may select more than one): AN = Alaskan Native WH = White BL = Black or African American AI = American Indian AS = Asian PI = Native Hawaiian or other Pacific Islander					

Housing Assistance. Do you receive a housing voucher or cash assistance for housing? Yes No
 (Mark "No" if living on a military installation)

Work Activity / Earned Income in Your Family. Include wages, salary, tips, bonuses and commissions, from all jobs received or that is expected to be received for all the adults in your family. (See definition of family on Page 2 of the application checklist). Attach proof of employment, wages and earnings.

Family Member Name (First, Middle, Last)	Employer Name & City	Number of Hours Worked per Week	Start Date (MM/DD/YY)	Work Schedule to include the hours of day and days of the week	Hourly Wage	How Often are you Paid?
						<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____
						<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____
						<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____
						<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____

Other Eligible Activities. This includes seeking work and participation in an approved education or training program. Attach proof of course enrollment and financial aid account summary if activity is education.

Name of Person in Activity	Type of Activity <input type="checkbox"/> Seeking Work <input type="checkbox"/> Training/Education	Name of Training/ Educational Institution	Start Date (MM/DD/YY)	End Date (MM/DD/YY)
List the days and hours you expect to participate in each activity. If your schedule varies, please explain				
Total anticipated hours of all activities:				
Name of Person in Activity	Type of Activity <input type="checkbox"/> Seeking Work <input type="checkbox"/> Training/Education	Name of Training/ Educational Institution	Start Date (MM/DD/YY)	End Date (MM/DD/YY)
List the days and hours you expect to participate in each activity. If your schedule varies, please explain:				
Total anticipated hours of all activities:				

Deductible Child Support Expenses. Only legally obligated child support payments may qualify. Attach proof.

Does anyone in your family pay child support to someone outside of the home? Yes No
 If yes, name of person paying child support: _____ Monthly amount: \$ _____

Self-Employment. Include money received from all self-employment for all adults in your family engaged in self employment activities. Please attach proof of earnings and expenses or your previous year's tax return with Schedule C.

Family Member Name (First, Middle, Last)	Type of Business	Seasonal (S) or Year-round (Y) Activity?	Business Income- Last three months preferred	Business Expenses- Last three months preferred
		<input type="checkbox"/> S <input type="checkbox"/> Y		
		<input type="checkbox"/> S <input type="checkbox"/> Y		

Unearned Income. Do you or anyone in your family receive money from any other source (unearned income)? Yes No

List any other money you or anyone in your family receives other than earned income or self employment and **attach proof** for each type of unearned income received. The Alaska Permanent Fund Dividend is not counted for any member of your family.

Name of Person Receiving Unearned Income (First, Middle, Last)	Source of Unearned Income Amount Received / Frequency Received (example: weekly, bi-weekly, monthly...),			
	<input type="checkbox"/> Child Support	\$ _____ /how often _____	<input type="checkbox"/> ATAP	\$ _____ /how often _____
	<input type="checkbox"/> Native Corp. Distrib.	\$ _____ /how often _____	<input type="checkbox"/> SSA/SSI	\$ _____ /how often _____
	<input type="checkbox"/> Education Financial Aid	\$ _____ /how often _____	<input type="checkbox"/> UIB	\$ _____ /how often _____
	<input type="checkbox"/> Adoption Payments	\$ _____ /how often _____	<input type="checkbox"/> VA	\$ _____ /how often _____
	<input type="checkbox"/> Foster care payment	\$ _____ /how often _____	<input type="checkbox"/> Guardian	\$ _____ /how often _____
	<input type="checkbox"/> Other: _____			
	<input type="checkbox"/> Child Support	\$ _____ /how often _____	<input type="checkbox"/> ATAP	\$ _____ /how often _____
	<input type="checkbox"/> Native Corp. Distrib.	\$ _____ /how often _____	<input type="checkbox"/> SSA/SSI	\$ _____ /how often _____
	<input type="checkbox"/> Education Financial Aid	\$ _____ /how often _____	<input type="checkbox"/> UIB	\$ _____ /how often _____
	<input type="checkbox"/> Adoption Payments	\$ _____ /how often _____	<input type="checkbox"/> VA	\$ _____ /how often _____
	<input type="checkbox"/> Foster care payment	\$ _____ /how often _____	<input type="checkbox"/> Guardian	\$ _____ /how often _____
	<input type="checkbox"/> Other: _____			
	<input type="checkbox"/> Child Support	\$ _____ /how often _____	<input type="checkbox"/> ATAP	\$ _____ /how often _____
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	<input type="checkbox"/> Foster care payment	\$ _____ /how often _____	<input type="checkbox"/> Guardian	\$ _____ /how often _____
	<input type="checkbox"/> Other: _____			
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	<input type="checkbox"/> Education Financial Aid	\$ _____ /how often _____	<input type="checkbox"/> UIB	\$ _____ /how often _____
	<input type="checkbox"/> Adoption Payments	\$ _____ /how often _____	<input type="checkbox"/> VA	\$ _____ /how often _____
	<input type="checkbox"/> Foster care payment	\$ _____ /how often _____	<input type="checkbox"/> Guardian	\$ _____ /how often _____
	<input type="checkbox"/> Other: _____			

ATAP = Alaska Temporary Assistance Program
UIB= Unemployment Insurance Benefit

SSA/SSI = Social Security Administration / Supplemental Income
VA= Veteran's Administration

Deductible catastrophic medical or dental payments. Attach proof if you answer yes to the question below.

Does your family have medical or dental payments that exceed 10% of the family's gross monthly income; payments have been made for more than 60 days and are projected to be an ongoing expense for more than six months? Yes No

Child custody arrangement. Your arrangement can be either court ordered or informally agreed upon. Attach the child custody arrangement portion of your court order, if applicable. An affidavit or written statement must be submitted if informally agreed upon.

Child's Name	Schedule child is with you. Please indicate days of the week and drop off/pick up times.	Court ordered <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Child's School Schedule. To determine the level of care needed for school aged children tell us your child's school information.

Child's Name	Name of Elementary School, Pre- Elementary or Head Start program each child attends	Days and Hours school is in session	How does each child get to and from school

Child Care Needs. Based on parent activities, custody/visitation and children's school schedules listed on the previous pages, tell us when each child will need care. The provider you select must be either Licensed or Approved to participate in the Child Care Assistance Program, by the State of Alaska or local designee, before any benefit will be paid on your behalf.

Child's Name	Days and Hours Child Care Needed	Primary Child Care Provider Name
	Days and Hours Child Care Needed	Secondary Child Care Provider Name
Child's Name	Days and Hours Child Care Needed	Primary Child Care Provider Name
	Days and Hours Child Care Needed	Secondary Child Care Provider Name
Child's Name	Days and Hours Child Care Needed	Primary Child Care Provider Name
	Days and Hours Child Care Needed	Secondary Child Care Provider Name
Child's Name	Days and Hours Child Care Needed	Primary Child Care Provider Name
	Days and Hours Child Care Needed	Secondary Child Care Provider Name
Child's Name	Days and Hours Child Care Needed	Primary Child Care Provider Name
	Days and Hours Child Care Needed	Secondary Child Care Provider Name

In-Home Provider Information.

Under limited circumstances you may select an individual to provide child care services in your home. You are considered the employer and are required to complete an additional application. You are responsible for compliance with all labor and IRS laws and requirements. There may be a lapse in eligible coverage as approval for in-home caregivers is based on the date the last item is submitted or completed by the caregiver and will not be the same date the family's eligibility may begin. This may require you to pay your caregiver out-of-pocket for child care. These costs will not be covered by this program.

Child care will be provided in my own home (In-Home Care) by (caregiver's name): _____

Statement of Truth

Under penalty of perjury or unsworn falsification, I certify that the statements made on this application and during my interview for assistance regarding the persons in my family, my family's income, participation in eligible activities, and all other items that pertain to my family's possible eligibility for Child Care Assistance are true and correct to the best of my knowledge. I have read "Your Rights and Responsibilities" portion of this application and by signing, agree to comply with the requirements for participation in the program.

Signature of Responsible Party

Date

Signature of Other Adult Applicant

Date

State Of Alaska
Department Of Health and Social Services
Division of Public Assistance
Child Care Program Office

Authorization For Release Of Information

I authorize the release of information requested by the Department of Health and Social Services, its grantees, or its agents within the Department of Law. The requested information will only be used in the administration of Child Care Assistance or other public assistance programs, and will not be released to any other person or agency outside the Department of Health and Social Services, its grantees, or its agents within the Department of Law.

This release of information will be in effect while I am an applicant or recipient of Child Care Assistance or other public assistance programs, and for any later investigations pertaining to my eligibility and program benefits.

Persons or organizations that may be contacted include, but are not limited to: employers, landlords, school authorities, Alaska Departments of Law, Labor, Revenue, Public Safety, Fish & Game, Military and Veterans Affairs; Bureau of Citizenship and Services; Alaska Housing Finance Corporation; Social Security Administration; tax assessors; financial institutions; stock brokerage firms; local governments; public assistance program contractors and grantees; Native corporations and private individuals.

Responsible Party Signature

Other Adult Applicant Signature

Printed Name

Printed Name

Address

Address

Phone Number

Phone Number

Date

Date

A Copy of this Release is as Valid as the Original.

Your Rights and Responsibilities

The information on this page is based on State Regulations 7 AAC 41 – Child Care Assistance Program

Your Responsibilities

As a participant in the Child Care Assistance Program you must report any changes in your circumstances that may affect your family's eligibility for Child Care Assistance within ten (10) days of when you know of the change. You must report the following to your local Child Care Assistance office:

- Changes in employment for any adult family member, such as starting or stopping a job, changes in pay, changes from part-time to full-time or full-time to part-time
- When your family size changes (see definition of family on page 2 of this application.)
- If you move or get a new mailing address
- Changes in any family member's legal obligation to pay child support
- Changes in earned or unearned income in excess of \$200 a month, or any other change that would affect your family's program benefits or eligibility
- When you are changing child care providers or are needing care authorized to a secondary child care provider

You must also:

- Give your provider at least 14 days written notice of your family's intent to terminate child care except:
 - In the case of sudden program ineligibility
 - In the case of an allegation of abuse, harm, or serious risk of harm to a child in the provider's care or
 - Upon written mutual agreement signed by the provider and yourself
- Pay your child care provider the difference between what your provider charges and what is paid on your behalf
- Pay your child care provider your monthly co-pay amount
- Renew your child care authorization in a manner timely enough to ensure continued coverage with your selected provider.
- If requested by the Department, review the provider's monthly billing statement to verify that care was billed for the hours that care was provided

Your Rights

You have the right to discuss any action taken on your application or case with your caseworker or with your caseworker's supervisor.

Administrative Reviews

If you disagree with a determination made by the local Child Care Assistance office, you may request an Administrative Review of the determination by the Department of Health and Social Services, Child Care Program Office. You may do this by submitting the *Request for Administrative Review* form, along with all required documentation within 15 days of the date you receive the notice of determination from the local Child Care Assistance office. Send your request to the: Child Care Program Office, 3601 C Street, Suite 140, P.O. Box 241809, Anchorage, AK 99524-1809 or Fax to: (907) 269-1064 or Toll Free: 1 (888) 224-4536

Fair Hearing Request

If you disagree with a decision made on a request for an Administrative Review, you may file a Notice of Appeal and Request for a Formal Hearing on the decision of the Child Care Program Office. An oral or written request for a Formal Hearing may be made to the Division by you or by a responsible person acting on your behalf. The request must be submitted within 30 days of the date you receive the decision from the Child Care Program Office. At the hearing you may represent yourself or be represented by a legal representative, friend or relative. You may contact the Alaska Legal Services Corporation to see if you may qualify for free legal advice and representation.

You may continue to receive Child Care Assistance benefits until a hearing decision is made. If the hearing decision is not in your favor you may be required to repay the benefits you received while you waited for the decision.

Civil Rights

Federal laws and regulations prohibit discrimination or the denial of participation on the basis of race, color, national origin, religion, sex, age, handicap or political beliefs in programs receiving federal financial assistance. To file a complaint of discrimination, write to the U.S. Department of Health and Human Services, Director, Office for Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington, D.C. 20250 or call (800) 795-3272 (voice) or (202) 720-6382 (TTD). Or write to HHS Office for Civil Rights, 2201 Sixth Avenue – Mail Stop RX-11, Seattle, WA 98121 or call (800) 368-1019 (voice) or (800) 537-7697 (TDD).

Americans with Disabilities Act of 1990

The Alaska Department of Health & Social Services and its grantees comply with Title II of the Americans with Disabilities Act of 1990. If you have questions, contact the Division's Americans with Disabilities Act Coordinator at (907) 465-3347.

Social Security Numbers

Social Security Numbers are not required for Child Care Assistance eligibility in accordance with 45 CFR 98.71(a)(13). Eligibility may not be denied due to the failure of the applicant to provide a Social Security Number.

Participation Requirements

To receive Child Care Assistance benefits, you must be participating in an eligible activity. In two-parent households both parents must be participating in an eligible activity, unless one parent is determined by a doctor to be incapacitated. Eligible activities include working, seeking work, and participating in an education or training program with the intent of improving your employability.

Fraud Penalty Warnings

Intentional Program Violation

You may be prosecuted or otherwise sanctioned if you knowingly give false, incorrect or incomplete information to try to get Child Care Assistance benefits you are not eligible for, or to help someone else get benefits to which they are not eligible. If you are found to have committed an intentional program violation or are convicted of defrauding the Child Care Assistance Program, you may be subject to service limitations, benefit reduction, disqualification from program participation, and be obligated to repay any benefits attributable to the intentional program violation or fraudulent act(s), in addition to any applicable criminal penalties.

Sanctions for Non-Compliance

Your participation in the Child Care Assistance Program may be suspended or terminated for any of the following reasons:

- Failing to report complete, accurate, and current information regarding family income and eligibility
- Failing to keep family income and eligibility information current with the local Child Care Assistance office;
- Failing to pay the family's co-pay amount of child care costs
- Failing to comply with family responsibilities for participation in the program
- Refusing to cooperate with a review or investigation by a representative of the Department or designee regarding eligibility for benefits or provision of services by a participating provider under the program or
- Failing to comply with any compliance action or corrective action plan or to cooperate with the establishment of the plan

If the Department determines that there is reasonable evidence of an overpayment of program benefits, the Department may take corrective action including: establishment of a repayment plan, program suspension for up to 6 months, or termination from the Program.

Overpayment of benefits means program benefits received by a family that the family was not entitled to or that were received while in non-compliance with a program requirement.