COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
An Equal Opportunity Employer M/F/D

CASE NAME: [redacted]
CLAIM NUMBER: CC-[redacted] -01
DATE: 07/06/10

[redacted]
P O BOX [redacted]
PINE KNOT KY 42635

On 07/06/10 you agreed to pay $40.00 by the 6th of every month for Child Care benefits you should not have received for the months of 12/2009 to 02/2010.

Please make payment by check or money order payable to the **Kentucky State Treasurer**. Do not send cash.

Send payment to:

Cabinet for Health and Family Services
Claims Management Section 3E-I
275 East Main St.
Frankfort, KY 40621

Please write this claim number, CC-[redacted] -01, and any other claim number to which you want this payment to be applied to on your check or money order.

We will send you a receipt showing the amount you paid and what you still owe.

If you have any questions concerning this claim, please contact the Child Care Service Agent in your area at (606) 549-4505.

If you want legal help or advice, call your attorney or local legal aid office at: (606) 679-7313.

Tear here and return the bottom portion with your payment in the enclosed envelope.

NAME: [redacted]

CLAIM NUMBER: CC-[redacted] -01

SOCIAL SECURITY NUMBER: [redacted]

GENERAL CLAIMS NOTICE
KCD2

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
An Equal Opportunity Employer M/F/D

KCD2.08

CASE NAME: [redacted]
CLAIM NUMBER: CC-[redacted] -01
DATE: 07/06/10

[redacted]
P O BOX [redacted]
PINE KNOT KY 42635

Your household received $850.00 more CHILD CARE benefits than you should have for the months of 12/2009 through 02/2010. The reason for this is: other technical ineligibility.

The Commonwealth of Kentucky is allowed to collect this debt based on KRS 205.211.

Please make payment by check or money order payable to the **Kentucky State Treasurer**. Do not send cash.

Send payment to: Cabinet for Health and Family Services
Claims Management Section 3E-I
275 East Main St.
Frankfort, KY 40621

Payment is due to this office within 20 days from the date of this letter.

Please write this claim number, CC-[redacted] -01, and any other claim number to which you want this payment to be applied to on your check or money order.

If you have any questions concerning this claim, please contact the Child Care Service Agent in your area at (606) 549-4505.

Tear here and return the bottom portion with your payment in the enclosed envelope.

NAME: [redacted]

CLAIM NUMBER: CC-[redacted] -01

SOCIAL SECURITY NUMBER: [redacted]

Kentucky
UNBRIDLED SPIRIT

Child Care Council of Kentucky
Child Care Assistance Program
1460 Newtown Pike
Lexington, KY 40511
Phone (859) 254-9176 or (877) 316-3552
Fax (859) 389-8585
www.childcarecouncilofky.com

Bradley Stevenson, Executive Director

June 7, 2010

[redacted]
P.O. Box [redacted]
Pine Knot, KY 42635

Dear [redacted],

This letter is regarding an overpayment from the Child Care Assistance Program. Enclosed you will find two copies of a *Repayment Agreement.* Please sign and return a copy of this agreement within 10 days of the date of this letter. The second copy is for your records.

If you have any questions or concerns regarding the agreement or would like to discuss the payment amount and due date, please contact the CCAP Claims Department at (800)809-7076 or (859)254-9176 immediately. If you do not respond, your case will be forwarded to the Division of Child Care for further processing.

Please return your completed forms to:

Child Care Council of Kentucky
Attn: Claims Department
1460 Newtown Pike, Suite 101
Lexington, KY 40511

You will receive a payment notice notifying you when your payment is due. Checks or money orders should be made payable to **KENTUCKY STATE TREASURER** and mailed to the address listed on the repayment agreement. Thank you for your assistance in this matter.

Sincerely,

Crystal Ross

Claims Specialist
Child Care Assistance Program
Child Care Council of Kentucky

DCC - 98
(R. 03/08)
922KAR2:160

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

R

Repayment Agreement

Name:	[redacted]	Date of Birth: [redacted]	Date: 6/7/10
Address:	PO Box [redacted]	SSN/FEIN:	[redacted]
City, ST Zip:	Pine Knot, KY 42635	Eligibility Code:	CCIE
Phone:	[redacted]	Amount Owed:	$850.00
☐ Provider ☒ Client		First Payment Due On: 7/19/2010	
Agreed monthly payment amount:	$40.00		

Reason for Repayment:
Client failed to report medical leave and married in November 2009. Claim period from 12/1/09 to 2/4/10.

Make check or money order payable to *"Kentucky State Treasurer".* Include your social security number or FEIN and note it is for child care repayment on the memo line. Do not send cash payments.

Checks or money orders should be mailed to:
Cabinet for Health and Family Services
Department for Community Based Services
Division of Family Support
Claims Management Section
275 E. Main, 3E-I
Frankfort, KY 40621

Failure to sign this agreement or subsequent default on more than three (3) payments shall result in discontinuance of CCAP payments in accordance with 922 KAR 2:160 Section 15.

Provider/Client Signature: _____ Date: _____

Service Agent Staff Signature: Crystal Ross, Claims Specialist Date: 6/7/10