STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bureau for Children and Families
Office of Children and Family Policy
Division of Family Assistance
350 Capitol Street, Room B-18
Charleston, West Virginia 25301-3705
Telephone: (304) 558-8290 Fax: (304) 558-2059

LIEAP REPAYMENT AGREEMENT

Date:_____
Client's Name:_____
Case Number:_____

I agree to repay the West Virginia Department of **Health and Human Resources (DHHR)** $ _____ which I received in the form of _____ to which I was not entitled.

I AGREE TO REPAY BY ONE OF THE FOLLOWING METHODS:

☐ I agree to pay $ _____ a month by cashier's or certified check or money order made payable to **DHHR** for _____ month(s) beginning with _____ and ending _____.

☐ I agree to repay the **DHHR** $ _____ on or before (Date) _____ by cashier's or certified check or money order.

☐ The vendor agrees to repay $ _____ by _____. If repayment is not made by that date, I am responsible for making repayment on or before _____.

I understand and agree with the statement below:

Any and all overpayments, ineligible payments intended for others but received by me or on my behalf in error must be repaid to the **DHHR.**

If I pay monthly by cashier's or certified check or money order, my payment must be received by the Department before the 15th of each month.

All payments should be sent to the **local County DHHR Office**.

_____ _____
Client's Signature Date

_____ _____
Worker's Signature Date

_____ _____
Supervisor's Signature Date