
**FOOD AND NUTRITION SERVICES CERTIFICATION
CLAIMS
Inadvertent Household Error (IHE) Claims**

FNS 815 Inadvertent Household Error (IHE) Claims
Change #3-2017
September 20, 2017

815.01 GENERAL POLICY

- A. A claim must be established within 12 months from the date the referral was created in Enterprise Program Integrity Control System (EPICS).

Discovery means that the agency is aware of sufficient facts to suspect that an overissuance occurred by completing a DSS-1682.

- B. **Establish a claim for any months of overissuance which occurred within six years prior to the Date of Discovery.** Do not include in the claim calculation any amount of the overissuance which occurred in a month more than six years from the date the overissuance was discovered.
- C. Use policy in effect at the time the overissuance occurred.
- D. Regardless of the detection source, all potential Food and Nutrition Services (FNS) overissuances must be reviewed timely to determine if referral to Program Integrity staff is required. The referral must be investigated, a claim established, if appropriate, and a suspected Intentional Program Violation pursued within required time frames. If an overissuance is due to an Inadvertent Household Error, establish the claim within 180 days from the Date of Discovery.

Enter established claims in EPICS before the 180th day or close unsubstantiated referrals in EPICS before the 180th day to prevent an untimely referral. All potential overissuances must be investigated even if the timeliness standards cannot be met.

If the process of establishing a claim is not completed within the time frames listed in 815.01 D, 1-5, the case is considered overdue. Federal regulations require that time frames be tracked and corrective action implemented when more than 10% of referrals in a local agency are more than 180 days old. Local agencies should monitor the following monthly reports FRD-407 Timeliness Report and FRD-420 Caseload Details By Investigator to ensure counties are within the 10% timeliness requirement.

1. Create the referral in Enterprise Program Integrity Control System (EPICS) within 10 business days of detection of a potential overissuance. This establishes a file in EPICS to track the claim and establishes the referral's Creation Date.
2. Request all necessary verifications within 30 calendar days of receipt of the referral, if possible.
3. Allow 30 calendar days for the return of the requested verification.
4. Determine whether or not there is a suspected Intentional Program Violation within 60 calendar days of the substantiation date of the potential overissuance.

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5. Complete a DSS-1682 and enter a Date of Discovery in EPICS within 180 days from the Creation Date. Establish the AE claim in EPICS within 180 days from the Date of Discovery.

E. Establish a claim regardless of the amount if Quality Control discovers the overissuance.

F. Do not establish a non-QC overissuance claim that is \$125.00 or less unless one debtor is currently participating in FNS. This applies unless your local agency has a State approved Claims Management Plan for a different threshold amount.

When a claim is established and there are multiple debtors, enter all debtors in EPICS whether they are currently participating in FNS or not on the same day the claim is established.

815.02 DETERMINING THE FIRST MONTH OF OVERISSUANCE

A. The Simplified Reporting Category applies to all FNS units except for:

1. A SNAP FNS unit.
2. A Transitional FNS unit.

Refer to Section 400 for Simplified Reporting Category.

B. Apply the following rules for applications and recertifications to determine the first month of overissuance.

1. The 10-10-10 rule referred to in this section allows:
 - a. 10th of the month, following the month of change, for a household to report a change in situation; and,
 - b. 10 calendar days for the caseworker to react to the change. 10 days are allowed even if the caseworker could have reacted sooner; and,
 - c. 10 work days for Notice of Adverse Action.
2. Applicant Households (Initial, Reapplications, and Late Recertifications)
 - a. The first month of overissuance for information reported incorrectly at the time of the application interview is the first month of the certification period.
 - b. An applicant household is required to report changes which occur after the date of the interview, by the 10th of the month, following the month in which the notice of eligibility is received. To establish the first month of overissuance, apply the 10-10-10 rule from the month after the month in which the notice of eligibility is received.

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3. Ongoing Cases

- a. The first month of overissuance is the first month affected had the change been reported timely.
- b. All ongoing households are required to report changes by the 10th of the month, following the month of the change. The month a participant first becomes aware of a change is the month that a change becomes known to them. Use this month to determine the month to report.
- c. Reportable changes for Simplified Reporting cases are:
 - (1) An increase in income that causes the FNS unit to exceed the maximum allowable gross income limit for its size (130% of the poverty level).
 - (2) FNS units that include an ABAWD must report when the ABAWD stops working an average of 80 hours per month (non-waiver counties).
- d. If you are unable to determine the month the participant first became aware of the change, use the month the participant started work or received the first check (for example, SSA, SSI, VA).
- e. Once the month of change is established, allow the household until the 10th of the following month to report.

Allow ten calendar days for the agency to act on the change, even if the local agency may have acted sooner. Also, allow ten working days for the Notice of Adverse Action to expire. Document the 10-10-10 dates on the DSS-1682.

EXAMPLE: A Simplified Reporting recipient begins a new job May 1. According to the 8550, the household is over 130% of the federal poverty level. The client does not report the new income, and certification ends October 31. The new income should have been reported by June 10. Allow 10 calendar days for the caseworker to react to the change or June 20, and 10 work days NOAA would have expired July 7. The first month of overissuance is August. Calculate actual income for each month of the certification period.

4. Recertifications

Recertifications are completed by the FNS unit household to continue eligibility. The first month of the new certification period is the first month of overissuance when the recipient does not report changes or anticipated changes at recertification.

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- a. If a change is not reported at recertification interview, the first month of overissuance is the first month of the new certification period.

EXAMPLE: Certification period expires April 30. Recertification interview was held April 4. Client was hired for a job on April 2. May is the first month of overissuance.

- b. If a change is not known or anticipated at recertification, the client is required to report the change by the 10th of the month, following the month in which the notice of eligibility is received.

EXAMPLE: Certification period expires April 30. Recertification interview was held April 4. Client was hired for a job on April 11. The case was processed on April 20. Allow three mailing days for client to receive the notice of eligibility, April 23. This change must be reported by May 10.

Allow ten calendar days to act, or May 20. Allow the ten-working day Adverse Action Notice to expire June 5. July is the first month of overissuance.

See DSS-8561 for assistance in determining the first month of overissuance for Simplified Reporting cases.

815.03 DETERMINING THE OVERISSUANCE AMOUNT

- A. Verify participation. Do not include in the claim calculation any months in which the household did not participate. Check the benefits in NC FAST on the Person Page under the Financial Transactions tab.
- B. Use the actual unreported income received by each household member, actual expenses for deductions (except for utility expenses), and other household circumstances for unreported information/changes. Refer to Section 4080.22 Deductions, of the North Carolina Integrated Eligibility Manual, Utility Expenses, for allowable utility expenses.

Do not re-verify reported income unless there is reason to believe the income is not representative. Continue to budget the actual anticipated converted amount that was used in the original budget. Use deductions that were allowed in the original budget. Budget actual verified allowable deductions for all expenses, except utilities. Consider ineligible and disqualified members when determining the appropriate utility and standard deductions. Refer Section 4080.22, Utility Deductions of the North Carolina Integrated Eligibility Manual.

EXCEPTION: Do not allow the earned income deduction for that portion of the earned income which was not reported. If the household reports part but not all of earned income, allow the deduction on the part that was reported. Using the Program Integrity trial budget, enter the unreported earnings as “unearned” income to disallow the earned income deduction.

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Use the Program Integrity trial budget for calculation. The claim amount is the difference between the correct allotment and the allotment the household received.

EXAMPLE: The household reported receipt of ongoing weekly contributions but failed to report wages. Apply the 10-10-10 rule. The overissuance budget should reflect the converted weekly contribution already budgeted and actual earned income for each overissued month. Complete the Program Integrity trial budget, entering the unreported earned income as unearned income to disallow the earned income deduction.

NOTE: See Sections 815.02 to determine the first month of overissuance.

- C. For each month of the overissuance, verify each source of unreported income. Use actual income, and do not convert.

Use Division of Employment Security (DES) wage match for verification when actual wages are not available. Use the gross quarterly income, divided by three months, to obtain the average amount per month. If the employment was less than three months, average the gross amount over the period of time between the start and stop dates of employment. Refer to 815.04, Determining the Overissuance Amount When Verification Cannot Be Obtained.

The initial month of overissuance must be determined through contact with the client or employer to obtain the date of first pay. If the client fails or refuses to provide necessary information or the information cannot be obtained from a third party, refer to Section 815.04, B, Client Failure to Cooperate, for further instructions, because it is possible that the amount of the claim cannot be determined.

- D. Consider any countable income from certain ineligible and all disqualified household members. See Section 260, Whose Income Is Counted?
- E. Verify and allow dependent care expenses each month as a deduction. Allow only the amount the FNS unit is responsible for paying. If unreported information makes a household eligible for a medical deduction, verify and allow actual expenses as a deduction.
- F. Count money from means-tested State and federal assistance (for example Work First and SSI) payments intended for the overissued month even if mailing cycles result in the receipt of two payments in one month and none the next month. For other income, count income in the month received.

EXAMPLE: SSI payments are received December 1 and December 31 and none in January due to the January 1 holiday. Count one payment each for December and January.

- G. For payments that are mailed, add three days mailing time to the date of the check to determine the month received.
- H. Count the actual amount of Work First, SSI, RSDI, or VA received, even when it represented an erroneous payment.

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- I. Do not include in the computation any portion of income that was a lump-sum payment unless the lump sum includes the current month's benefit payment.
- J. Count the prorated or annualized income amount for each month of overissuance, even in months when the income was not actually received (Example: Annualized Self-employment Income).
- K. Do not include in the computation any month in which the FNS unit received Transitional Food and Nutrition Services unless there was dual participation by a member of the FNS unit, or an out-of-state IPV disqualification was not imposed timely.
- L. Count the gross Social Security amount when a federal offset occurs to a Social Security payment. BENDEX will continue to show the gross amount and will not record any information regarding the offset. Use the BENDEX record as verification of the gross amount.
- M. Complete a DSS-1682, Report of Erroneous Issuance.
 - 1. Document the DSS-1682 to substantiate the determination of the first overissuance month. See Section 835, Report of Erroneous Issuance (DSS1682), for instructions.
 - 2. Attach appropriate verification.
 - 3. Attach the Program Integrity trial budget printouts
 - 4. A second party review of the DSS-1682 by a supervisor to ensure its accuracy and completeness is required.
- N. When using actual income and deductions on the DSS-1682, an underissuance may occur. If the amount of the correct allotment (Item 8j.) is greater than the amount of the allotment received (Item 8i.), use "0" in both Items 8i. and 8j. for that month. Do not include any month in which this occurs in the total overissuance calculation.
- O. For overissuances which involve both agency and client responsible errors in the same month, establish two claims.
 - 1. First, calculate the agency responsible overissuance. The result from Item 8j. on the DSS-1682 represents the correct allotment taking into consideration the agency errors only.
 - 2. Complete another DSS-1682 to determine the client responsible overissuance. Use the figures from Item 8j. (Correct Allotment) on the AE claim for the corresponding months in Item 8i. (Allotment Received) on the IHE claim.
 - 3. Then in Item 8j. (correct basis of issuance) on the IHE claim, use all corrected information, both agency and client responsible. The result from the second DSS-1682 represents the client responsible portion of the erroneous issuance.

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EXAMPLE: An overissuance was determined because the income maintenance caseworker (IMC) failed to react to a Bendex that showed an increase of more than \$100.00 per month of SSA benefits. The household also failed to report a new source of earned income which began in the same month.

NOTE: See Sections 815.02 to determine the first month of overissuance.

Complete the first DSS-1682, using only the correctly budgeted SSA payment. This is the AE claim. Complete the second DSS-1682, using the figures from Item 8j. (Correct Allotment) on the AE claim as the actual basis of issuance in Item 8i. on the IHE claim. In Item 8j. of the IHE claim, use the correctly budgeted SSA payment and unreported earnings. The result of the second DSS-1682 is the client error.

- P. Enter the appropriate portion of the claim information in EPICS as an IHE claim and enter remaining information concerning the claim. The date established is the date the worker determines the overissuance amount and enters the claim into EPICS.
- Q. If the agency is aware of an expungement of benefits occurring within the previous three years, adjust the claim in EPICS. Enter the amount of the expunged benefits as the payment amount and "EX" – Expungement as the method of collection on the payment screen.
- R. Follow the procedures in Section 815.03, O when an Agency Error caused an underissuance during the same time as an IHE or IPV. Complete a DSS-1682 for both. Establish a claim in EPICS for the overissuance. Apply the AE underissuance to the claim as restored benefits following policy in section 815.06, A, 4. Do not calculate an underissuance when the applicant/recipient did not report timely the change that caused the underissuance.

815.04 DETERMINING THE OVERISSUANCE AMOUNT WHEN VERIFICATION CANNOT BE OBTAINED

- A. Third Party Fails/Refuses to Cooperate

If a third party fails/refuses to provide requested verification, take the following actions:

1. Send a second request if a response is not received from the first request for verification within 30 calendar days.
2. Contact the client if a response to the second request is not received within 15 calendar days. Use the DSS-8231 to request the necessary verification or assistance in obtaining the verification. Do not require the client to come into the office or make threats to obtain cooperation or a response.
3. Calculate the overissuance using wage match or other readily available sources allowed by law if the client is unable to provide the required verification.

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4. It is not possible to establish a claim when verification cannot be obtained from any source. Document and flag the certification record and claims file that there is an outstanding investigation in which a claim cannot be established.
5. Do not terminate a case or deny future participation if the claim cannot be established due to the failure or refusal of a third party to cooperate. Unsubstantiate and close the referral in EPICS. Open a new referral if the verification becomes available later.
6. Document the partially completed DSS-1682 as a suspected overissuance and the reason the claim has not been established. Open a new referral if the verification becomes available later.

B. Client Failure/Refusal to Cooperate with the Investigator

If the client fails/refuses to provide verification or refuses to authorize a third party to release information, do not consider the household totally ineligible for the months when a suspected overissuance may have occurred. Use the DSS-8231, Request for Information, to obtain the verification. Do not require the client to come into the agency. Take the following actions.

1. Calculate the overissuance using information verified through any readily available source. For example, use wage match for unreported wages. If the client contests the use of wage match and verification is subsequently received, recalculate the claim using the verified information.
2. It is not possible to establish a claim if verification cannot be obtained. Document and flag the certification record and the claims file that there is an outstanding claim which cannot be established.
3. Document the partially completed DSS-1682 as a suspected overissuance and the reason the claim has not been established. Unsubstantiate and close the referral in EPICS. Open a new referral if the verification becomes available later.
4. If the client subsequently cooperates, open a new referral and establish a claim.

815.05 CLIENT INTERVIEWS

- A. Do not require a client under investigation to come into the agency to discuss the amount of the claim or the type of the claim. A client's participation during an investigation is strictly voluntary. Use DSS-8230, Program Integrity Appointment Notice to notify client of the appointment.
- B. Schedule and conduct a home visit with the household, if appropriate. Use DSS-8230, Program Integrity Appointment Notice to schedule and notify client of a home visit.
- C. Continue the investigation if the client does not cooperate with the interview or home visit. Establish a claim without a client interview, if the client does not keep the appointment, and the evidence is clear and convincing to prove the overissuance.

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815.06 COLLECTING THE IHE CLAIM

A. Initiating Collection Action

1. Collection action is initiated when the claim information is entered into EPICS. Enter each claim, including those where the total amount of the claim is collected through restoration offset. See 815.05, A, 4.
2. EPICS sends the DSS-8554, Letter of Overissuance, to all debtors entered. The DSS-8554 incorporates a repayment agreement for nonparticipating households. A DSS-8554 is not sent when a change in the category of claim type occurs. A DSS-8554 is sent when a claim type of U or P is changed to be an IHE.
3. An individual debtor with multiple claims is not considered delinquent as long as one claim is being paid in accordance with a repayment agreement or through allotment reduction.
4. Restored benefits are benefits owed to the recipient for prior months. Supplement benefits are benefits owed to the recipient in the same month. Do not restore benefits for any period more than 12 months old. EPICS and NC FAST will not issue restored benefits nor a supplement when the debtor has a claim in EPICS. Calculate the amount of restored benefits or supplement owed to the recipient, and post that amount as a payment in EPICS with a payment type code of O. Document your actions in the eligibility file and in EPICS notepad.
5. All household members who were 18 years old or older at the time of the overissuance are debtors on the claim. This includes household members that were not reported to the Agency. Do not include as debtors any household members who were not in the household at the time of the overissuance.

B. Participating Household

1. The DSS-8554, Letter of Overissuance, notifies the participating household that an allotment reduction will be effective the month following the month in which the ten working day notice expires.
2. The household may only request a Fair Hearing, within 90 days of the DSS-8554, Letter of Overissuance, if they disagree with the amount of the claim established, the recoupment amount, or the household states the claim has been previously paid in full. Continue benefits on the basis authorized immediately prior to the notice if the household requests a Fair Hearing within the 90-calendar day period and the household's certification period has not expired.

All collection action ceases once a Fair Hearing is requested. Upon request for a Fair Hearing, enter "X" in the Appeal Indicator field on the Debtor Detail screen in EPICS and document in EPICS. Send the State Office a written request to block the debtor from TOP and DOR interception until a hearing decision is received. The request must be signed by the Investigator and Program Integrity Supervisor

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and contain justification for the request. Fax the request to the State Office/Attn: Program Integrity to 919-334-1265. Request removal of the TOP and DOR blocks once the hearing decision is received and document in EPICS. Fax a request with two signatures to State Office/Attn: Program Integrity to 919-334-1265. If a recoupment improperly occurs after a request for an appeal, restore the amount recouped until the appeal is resolved.

Mail DSS-8658 Post Hearing Repayment Notice after the 10th day once the local agency has verified the debtor did not contest the Fair Hearing decision. The local agency must verify that the Fair Hearing decision has not been contested with Hearing and Appeals Section by phone at 919-855-3260 if a notice is not received by the 10th day. The date of the DSS-8658 must be entered by the local agency in EPICS on the Debtor Detail screen. Do not allow a Fair Hearing past the 90th day as written on the DSS-8554.

Example: An IHE claim is established on September 10. The DSS-8554 is sent to the FNS unit. The ninety calendar days from the Letter of Overissuance expires on December 9. A recoupment of \$10.00 began on December 1. The debtor requested a Fair Hearing on December 5. The Investigator will place "X" in the Appeal Indicator, so that recoupment will not proceed for January.

The following should occur when a Fair Hearing decision is remanded back to the local agency:

- a. The local agency should recalculate the overissuance.
- b. No action can be taken until the local agency verifies with Hearings and Appeals Section that the debtor has not contested the remand decision. If the debtor does not contest the decision within 10 calendar days, the local agency must send a DSS-8658, Post Hearing Repayment Agreement.
- c. The date of the DSS-8658 must be posted in EPICS on the debtor detail screen.
- d. Document in EPICS.

Note: A debtor may not appeal the DSS-8658 after a claim has been remanded back to the local agency.

3. If the household contacts the agency to make an additional payment, accept a lump-sum payment, FNS benefits, or a cash payment. Key the cash payment in EPICS with a code of "FSC". When "FSC" is entered as the method of payment in EPICS, this tells EPICS and NC FAST that a cash payment is being made in addition to that month's recoupment. NC FAST will not increase the amount of recoupment beyond the standard 10% or \$10, whichever is greater. A debtor may choose to voluntarily debit their EBT account. See section 815.08 D, 4, a.
4. NC FAST will automatically begin an allotment reduction when the last cash payment date is more than 60 days old.

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5. Participating households that do not wish to be recouped may choose to make a cash payment. The participating households must agree to pay more than 10% of the allotment or \$10, whichever is greater **prior to recoupment**. If the participating household agrees to make the cash payments, key the cash payments in EPICS using a payment type of "C" – Cash. This will stop a recoupment from occurring.

C. Nonparticipating Household

1. The DSS-8554, Letter of Overissuance, notifies the nonparticipating household of the methods of repayment available and the requirement to return the signed notice within ten days. If the notice is not returned by the deadline, the local agency will initiate further collection action, as appropriate, to include civil court or tax intercept.
2. The household may only request a Fair Hearing within 90 days of the date of the Notice of Overissuance, if they disagree with the amount of the claim established or that the claim has been previously paid in full. All collection action ceases once a Fair Hearing is requested. Upon request for a Fair Hearing, enter "X" in the Appeal Indicator field on the Debtor Detail screen in EPICS. Document this in EPICS. Fax the State Office a written request to block the debtor from TOP and DOR interception until a hearing decision is received. The request must be signed by the Investigator and Program Integrity Supervisor and contain justification for the request. Fax the request to 919-334-1265. Request removal of the TOP and DOR blocks once the hearing decision is received. Fax a request with two signatures to State Office/Attn: Program Integrity to 919-334-1265.

Mail DSS-8658 Post Hearing Repayment Notice after the 10th day once the local agency has verified the debtor did not contest the Fair Hearing decision. The local agency must verify that the Fair Hearing decision has not been contested with Hearing and Appeals Section by phone at 919-855-3260 if a notice is not received by the 10th day. The date of the DSS-8658 must be entered by the local agency in EPICS on the Debtor Detail screen. Do not allow a Fair Hearing past the 90th day as written on the DSS-8554.

The following should occur when a Fair Hearing decision is remanded back to the local agency:

- a. The local agency should recalculate the overissuance.
- b. No action can be taken until the local agency verifies with Hearings and Appeals Section that the debtor has not contested the remand decision. If the debtor does not contest the decision within 10 calendar days, the local agency must send a DSS-8658, Post Hearing Repayment Agreement.
- c. The date of the DSS-8658 must be posted in EPICS on the debtor detail screen.
- d. Document in EPICS.

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Note: A debtor may not appeal the DSS-8658 after a claim has been remanded back to the local agency.

3. Mail a written notice to a debtor who returns the repayment agreement portion of a DSS-8554 and it is not accepted by the local agency. Include in the notice why the repayment agreement is not accepted and what would make it acceptable.
4. EPICS automatically begins recoupment when a debtor that was not participating becomes active again. EPICS notifies TOP and DOR when a debtor becomes active in FNS or a Voluntary Repayment Agreement (VRA) is signed. No manual blocks should be applied for becoming active in FNS or having a VRA.

D. Methods of Payment

1. Lump Sum – If financially able, a household may pay in one lump sum. Do not require the household to use all its resources to make a lump-sum payment.
2. Cash Payments – If a debtor is unable to pay the claim in one lump sum, negotiate a cash Voluntary Repayment Agreement. Use DSS-8604 to document the repayment agreement. Enter the repayment agreement in EPICS in the repayment approach screen. Give a copy to the debtor or authorized representative. Once a DSS-8604 is signed by the debtor and local agency representative, it is considered binding unless the debtor defaults. Any VRA activity must be documented in EPICS.
3. Allotment Reduction – The allotment is reduced by 10% or \$10, whichever is greater. NC FAST recoups the entire allotment if the allotment is \$10 or less.

NOTE: Do not initiate allotment reduction on initial allotments. This applies to retroactive allotments and months where allotments are prorated. If multiple claims are outstanding, the recoupment will be posted to the oldest claim first.

4. Voluntary debit to active or reactivated EBT accounts.
 - a. A FNS unit can choose to make a voluntary payment from its EBT account toward an outstanding FNS claim, in addition to its allotment reduction. If it is a one-time reduction, the FNS unit may give oral permission, either in person or via telephone. For verbal one-time reductions, document the reduction on the DSS-8217, Account Debit Request. If it is not a one-time reduction, the FNS unit must provide written authorization to have the benefits deducted from the EBT account. The DSS-8217, Account Debit Request, must be completed, signed by the head of household and by the caseworker. In addition to the head of household, the head of household's spouse or authorized representative can provide authorization for the EBT debit.
 - b. The FNS unit may give written permission on the DSS-8217 in advance for EBT debits. This means that the FNS unit may give permission to do

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- an EBT debit for a particular amount each month for a specific period of time. The FNS unit may revoke this agreement at any time.
- c. The DSS-8217 must contain the following information:
 - (1) The amount of the payment,
 - (2) The frequency of the payment, i.e., monthly or one-time only,
 - (3) The period of time the agreement covers.
 - d. Once the recipient signs the DSS-8217, the EBT account debit is processed through the Adjustment/Repayment Screen of the eFunds administrative terminal. Procedures for this function are contained in the eFunds Administrative Terminal User's Manual. The debit is on-line and occurs immediately.
 - e. After the recipient's account, has been debited, enter the amount and date of the payment in EPICS. Enter the Method of Collection on the Payments Screen as "EB" – Electronic Benefit Transfer.
 - f. Within 10 calendar days of obtaining the FNS unit's written or oral permission for an EBT debit, give or mail the recipient his copy of the DSS-8217, Account Debit Request, noting the amount and date of the debit and the claim balance.
5. Involuntary and voluntary debits to stale (or dormant) EBT accounts (accounts not accessed for six (6) months or more):
- a. Stale EBT benefits may be used to repay an outstanding claim balance when there has been no debit activity on an EBT account for six (6) months or more. Stale benefits appear on the Aged Authorization Detail Report in XPTR.
 - b. Give or mail the FNS unit written notification of the local agency's intent to apply the EBT benefits to the outstanding claim. Give the FNS unit ten days to object to the use of the benefits to pay the claim.
 - c. If the FNS unit objects to the EBT account debit, do not process the debit.
 - d. If the FNS unit does not respond or object to the notification that an EBT debit will occur, apply the EBT benefits to the outstanding FNS claim balance. Process the EBT account debit on the Adjustment/Payment Screen of the eFunds administrative terminal. After the recipient's account, has been debited, enter the amount and date of the payment in EPICS. Enter the Method of Collection on the Payments Screen as "EB" – Electronic Benefit Transfer.

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6. Expungement:
 - a. If the household's benefits have been expunged within the previous three years, reduce the claim by the amount of the expunged benefits. Check Data Warehouse for expunged benefits prior to beginning collection action.
 - b. To apply the expungement to the claim in EPICS, enter the amount of the expunged benefits as the payment amount and "EX" – Expungement as the method of collection. No retention is received for expungements. Do not apply any amount which exceeds the claim balance.

EXAMPLE: If the expunged amount is \$100.00 and the claim balance is \$80.00, apply \$80.00 as the payment.
7. Treasury Offset Program (TOP) through the United States Treasury Department
 - a. Delinquent debts are automatically submitted to the US Treasury Department for interception of federal payments. If a TOP review is requested, follow policy in section 845.
 - b. See Section 845 for more information.
8. Department of Revenue (DOR) setoff through the NC Department of Revenue
 - a. Delinquent debts are automatically submitted to the NC Department of Revenue for interception of NC Income Tax Refunds.
 - b. See Section 850 for more information.
9. North Carolina Education Lottery (NCEL)
 - a. Delinquent debts are automatically submitted to the NC Education Lottery for interception of lottery winnings.
 - b. The selection criteria for NCEL and DOR interception is the same.
 - c. See Section 865 for more information.

E. Unspecified Joint Cash Collections

When an unspecified joint cash collection is received for a combined public assistance/ FNS recipient claim, each program must receive its prorated share of the amount collected. An unspecified joint cash collection is when payments are received in response to correspondence that contained both the FNS and other program claim(s) and the debtor does not specify to which claim to apply the collection.

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F. Compromising Claims

1. Any claim or any portion of a claim may be compromised (reduced) if the local agency can reasonably determine that a household's economic circumstances indicate that the claim will not be paid in three (3) years. For example, if the only debtor is in a nursing home, or is elderly or disabled and needs all current income, assets, and FNS for essential living expenses, compromise the remaining balance of the claim. To compromise a claim in EPICS, send a request for compromise to the State Office/Attn: Program Integrity. The request must include justification of the compromise and be signed by the Investigator and the Program Integrity Supervisor. Fax the request to the State Office/Attn: Program Integrity to 919-334-1265.
2. Restored benefits and supplements should be collected and applied to the full amount of the claim, including any claim amount that was compromised.
3. If a compromised claim subsequently becomes delinquent, the compromised portion of a claim may be re-instated and subject to collection. To uncompromise a claim in EPICS, submit a request to the State Office/Attn: Program Integrity signed by the Investigator and the Program Integrity Supervisor. Fax the request to State Office/Attn: Program Integrity 919-334-1265.

G. Termination of Claim

1. Do not terminate a claim against a participating household. To terminate an existing claim in EPICS, the claim must be Collection (CO) status and have a balance. Access the Referral Detail screen and key a "Y" in the CLOSE REFERRAL field, enter the code "TX" in the REASON CLOSED field and press the F9 key. The claim will show "TE" – Terminated status.

NOTE: Terminated claims are submitted to TOP, DOR, and NCEL for interception and to NC FAST for recoupment.

2. Terminate a claim if any of the following conditions exist:
 - a. If the claim:
 - (1) Balance is \$25 or less; and
 - (2) Has been delinquent for 90 days or more; and
 - (3) There are no other claims that exist against the household resulting in an overall claim balance greater than \$25.00.
 - b. The claim is delinquent for three years or more and will not be pursued through the Treasury Offset Program (TOP);
 - c. The household cannot be located, regardless of the balance.
 - d. The claim has been submitted for at least one year for TOP and State tax intercept and demand letters have been sent at least once every six months and you have sent at a minimum of:

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- (1) One follow-up demand letter for claims less than \$100.00;
 - (2) Two follow-up demand letters for claims of \$100 or more through \$400;
 - (3) Three follow-up demand letters for claims of more than \$400 and the cost of further collection action is likely to exceed the amount that can be recovered.
3. EPICS automatically terminates selected claims on the last working day of each quarter. Claims are selected when the last payment is more than 12 months old or when establishment date is more than 12 months old and there are no payments. Automatically terminated claims are listed by local agency in XPTR on report, FRD-750, Terminated Claims.
 4. Terminated claims may be reactivated if a new collection method or a specific event (such as winning the lottery) increases the likelihood of collecting the claim. To reactivate a terminated claim in EPICS, access the Claim Detail screen and key the Referral ID and press the F11 key. The claim will show "CO" - Collection status.
 5. EPICS automatically reactivates a claim when an intercept from the Treasury Offset Program (TOP), North Carolina Debt Setoff (DOR), NC Education Lottery (NCEL), or recoupment is posted.

815.07 OVERCOLLECTION OF CLAIMS

- A. Overcollections appear in EPICS in the overcollection column:
 1. On the Payment History by Referral Screen;
 2. On the Payment History by Individual Screen; and
 3. On the Payment Screen.
- B. Refund any overcollection to the household from recoupments. Use the DSS-8593 to restore benefits.
- C. Refund cash overcollections in cash or local agency checks.
- D. When a claim is overcollected through tax or lottery intercept, the State Controller's Office will issue the refund.

815.08 DELETION AND CLOSURE OF CLAIM

- A. Fax a written request for deletion to State Office/Attn: Program Integrity on local agency letterhead to 919-334-1265 when:

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1. A claim is found to be invalid in an ADH or State Level Hearing, or
 2. A claim is found to be invalid by the courts, or
 3. A claim is entered in EPICS in error.
 4. Due to system audit requirements, the following cannot be deleted, but may be adjusted and closed.
 - a. A claim with payment history.
 - b. A claim with a disqualification.
 - c. A claim with a debtor certified for TOP.
- B. Request an adjustment closure of claim when:
1. All debtors are deceased at least six months and the local agency has verified their estate is exhausted or they do not have an estate:
 2. All debtors filed bankruptcy, and the bankruptcy court has discharged the debt:
 3. All debtors are in a nursing home, and it is unlikely they will ever pay on the debt.
 4. The system will not allow deletion as in 815.10, A, 4 above.
- C. The request for deletion or closure must include:
1. Claim Name
 2. PDC Number
 3. EPICS Referral ID Number
 4. Individual ID Number
 5. Category of Claim
 6. Date Established
 7. Reason for deletion
 8. Name, Title, and Telephone Number of individual submitting claim for deletion
 9. Current balance as shown in EPICS
 10. Investigator's signature
 11. Program Integrity Supervisor's signature
 12. The date of death, if applicable.
 13. Justification for the request. Justification includes, but is not limited to: copy of death certificate, copy of bankruptcy order, etc.

Mail or fax the request to:

North Carolina Division of Social Services
Economic and Family Services/Program Integrity
820 S. Boylan Ave.
Raleigh, NC 27603

2420 Mail Service Center
Raleigh, NC 27699-2420
Fax: (919) 334-1265

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815.09 CLAIMS RECORD RETENTION

- A. Follow policy in Section 135 regarding retention of claims, with the following exception. Use the date of the last payment that paid the claim in full as the last transaction date.
- B. Records for IHE claims may be maintained electronically.