Childcare and Parent Services Program (CAPS)
Provider Repayment Statement

Please check one:
( ) AE – Administrative Error
( ) PE – Provider Error
( ) PV – Program Violation

Provider Name: _____

Provider Address: _____

_____

Provider CAPS ID Number: _____

DATE:

RE: CHILD CARE CLAIMS AND REPAYMENT STATEMENT

Dear _____,

It has been determined that you received an overpayment for child care services from _____ to _____ for $_____ which you were not eligible to receive. The reason for the overpayment is:
_____.

- ❑ If you believe this determination has been made in error, you must notify us in **writing within ten (10) calendar days** of the date of this letter to request a reconsideration. This notice must be postmarked within the ten day timeframe to be considered valid. Your request for reconsideration must include documentation that you used when you decided that the determination has been made in error. The Department will respond to your request and notify you of the findings within ten (10) calendar days of the receipt of your request. Your written request should be sent to the address below.

- ❑ If you understand the determination and do not wish to have a reconsideration, please select the appropriate box below and sign and date this repayment agreement. This agreement is to be returned to the address below.

GA Department of Early Care and Learning
Audit and Compliance Division
2 Martin L. King Jr. Drive, SE
Suite 754, East Tower
Atlanta, GA 30334
CAPS.Investigations@decal.ga.gov

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Providers who fail to contact the Audits and Compliance Division for a reconsideration within the ten calendar day window or providers who fail to return the signed repayment statement by the date listed above will have future reimbursements reduced without further notice. Offsets will be set at an amount to ensure overpayments are paid within 24 months.

_____

Audits and Compliance Examiner and Date

Child Care Provider

- ❑ I understand that I have been overpaid for child care in the amount of $_____. I have enclosed a cashier's check or money order to pay the claim amount. All cashier's checks/money orders should be made payable and should be sent to:

  GACAPS/MAXIMUS
  34 Peachtree Street NW
  Suite 2400
  Atlanta, GA 30303

- ❑ I understand that I have been overpaid for child care in the amount of $_____. I authorize CAPS, or its authorized agents, to withhold from any of my future child care payments beginning _____ and each payment thereafter until the entire overpayment is paid in full.

- ❑ I agree that I am not currently receiving a payment through MAXIMUS, and I will contact MAXIMUS to make payment arrangements. I understand that failure to pay my overpayment may result in actions that could further affect my participation in the CAPS program, leading to legal action and/or other penalties as assessed by GA Department of Early Care and Learning.

_____ _____

Legal Owner/Authorized Agent Signature Date