STATE OF MARYLAND
PAYROLL ADVANCE
REPAYMENT TERMS & CONDITIONS

Date: _____

To: Employee Social: | | | | - | | | - | | | | |

Employee Name: | |

From: Agency Code: | | | | | | |

Agency Name: | |

Subject: Payroll Advance Check Number

Repayment Terms & Conditions

I, _____hereby acknowledge that I have received a Payroll Advance in the amount of $ _____ on _____ (hereinafter "Payroll Advance"). This Payroll Advance was made by _____ (hereinafter "Agency") in response to my Payroll Advance Request dated _____. This is a Payroll Advance for the pay period:
Begin date: _____ End date:_____for Pay Date: _____ (hereinafter "Pay Period"), calculated using a rate of 60% of gross wages not paid.

I understand and hereby agree that I am required to reimburse the State in the amount of $_____ as repayment of this Payroll Advance. Reimbursement shall be made in cash, personal check, money order or an authorized payroll deduction **as soon as I receive my next system generated payment of wages inclusive of this payroll advance**. If reimbursement is made by personal check or money order, said instrument shall be made payable to _____. By signing this document below I acknowledge and agree that I will reimburse Agency in the amount of $ _____.

Should I not provide full reimbursement of the Payroll Advance within two weeks of receiving the full corrected pay for the Pay Period, I hereby authorize the Agency and the Central Payroll Bureau to process a payroll deduction equaling up to 50% of the unreimbursed amount of the Payroll Advance from my next payment of wages and the remaining balance from the next subsequent payment of wages. Furthermore, should my employment at the Agency end prior to my having fully reimbursed the Agency for the Payroll Advance, I hereby authorize any remaining unreimbursed amount to be deducted from my final payment of wages. If my final payment of wages is not sufficient to satisfy any remaining unreimbursed amount, I agree to pay the remaining unreimbursed amount by money order, payable to _____, within ten days of the date of written notice from the Agency, sent to the my last known address. Said notice will notify me of the amount of the remaining balance due and the address to which I should remit payment. I understand that if payment is not received within ten days of the date of the notice that the Agency will certify the liability to the State Central Collection Unit for further actions.

Moreover, if I disagree with this amount or I refuse to pay the amount due, the liability will be certified and sent to the State Central Collections Unit for further action.

I understand that certified liabilities to the State Central Collection Unit will be charged a 17% collection fee; which collection fee is assessed to the debtor.

I agree with the guidelines, terms and conditions set-forth in this request. By affixing my signature, I agree to honor all conditions of this request.

Employee Signature: _____ Date: _____

If you have any questions or require additional information, please contact the Agency representative identified below:

Authorized Name: _____

Authorized Signature: _____Date: _____

Title: _____ Phone Number: _____

Email: _____