**Partner Up! Voluntary Repayment Agreement**

**Use of form:** Use of this form is voluntary. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Instructions:** Please **return this completed form each time you submit a payment**. If paying via FIS Provider ID debit, email the completed form to [DCFMBDECEProjectGrowth@wisconsin.gov](mailto:DCFMBDECEProjectGrowth@wisconsin.gov) or mail to 201 W. Washington Ave, Madison, WI 53703. If paying via paper check, mail the completed form **along with your check** to 201 W. Washington Ave, Madison, WI 53703.

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| **Section A: Provider Information** | | | | | | | | | | |
| Business Name | | | | | | | | | | |
| Provider and Location Number | | | | | | | FIS Provider ID (leave blank if paying by paper check) | | | |
| **Section B: Repayment Amounts** | | | | | | | | | | |
| Clearly identify each child that the Partner Up! funds were improperly paid, and the amount you are returning. Each Partner Up! payment was intended for a specific child’s care and should be clearly identified in the chart below. Do not combine amounts for multiple children on one line. | | | | | | | | | | |
| Pay in full (preferred)  Pay in monthly installments. Total amount per month: $ | | | | | | | | Pay via FIS Provider ID debit  Pay with paper check | | |
| A. | | DCF Contract ID | | | Child Name | | | | Total Amount Returned  $ | |
| B. | | DCF Contract ID | | | Child Name | | | | Total Amount Returned  $ | |
| C. | | DCF Contract ID | | | Child Name | | | | Total Amount Returned  $ | |
| D. | | DCF Contract ID | | | Child Name | | | | Total Amount Returned  $ | |
| E. | | DCF Contract ID | | | Child Name | | | | Total Amount Returned  $ | |
| **Section C: Reason for the Voluntary Repayment(s).** Select all that apply. | | | | | | | | | | |
| Payment Made to the Incorrect Provider or Location  Child Left Provider  Incorrect Amount Paid  Other: | | | | | | | | | | |
| **Section D: Attestation** | | | | | | | | | | |
| Carefully read all statements and check “Yes” or “No” to indicate your consent for the following: | | | | | | | | | | |
|  | **Yes** | | **No** | **N/A** | |  | | | | |
| 1. |  | |  |  | | I hereby authorize and direct the vendor Fidelity National Information Services (FIS) and the Department of Children and Families (DCF) to debit the amount above from the bank account registered with FIS, due to the reason(s) identified in Section C above. **Select N/A only if paying by paper check.** | | | | |
| 2. |  | |  |  | | I understand that the amount indicated in Section B above will be removed from my bank account with the Department’s receipt of this form and acknowledge that the amount above is available to be removed as of the date of the signature of this form. | | | | |
| 3. |  | |  |  | | I understand that if the funds are not available when the debit is initiated, I may be liable for the unreturned funds and an additional fee of $0.50 that will have to be repaid to DCF | | | | |
| 4. |  | |  |  | | I understand and voluntarily waive any potential right to appeal this recovery of funds, now or in the future. | | | | |
| The Department reserves the right to terminate this voluntary repayment agreement at any time. | | | | | | | | | | |
| Provider Contact Name (Print) | | | | | | | | | | |
| Provider Contact Signature | | | | | | | | | | Date Signed |