DEPARTMENT OF CHILDREN AND FAMILIES
Division of Family and Economic Security

Request for Reissuance of a Stale-Dated Check

PLEASE SEE INSTRUCTIONS ON THE BACK OF THIS PAGE

Mail to:
Bureau of Child Support
P.O. Box 7935
Madison WI 53707-7935

Information provided on this form (including any attachments) may be shared with others only for the purpose(s) of administration of the child support program and other related programs [Wis. Statutes, s.49.83]

The provision of your Social Security number is mandatory under Section 466(a) (42U.S.C.666(a)). Your Social Security number will be used for identification purposes. If you do not provide your Social Security number, your application will be denied.

Payee Name on the Original Check	Claimant (Your) Telephone Number ( )
Payee Social Security Number	KIDS Personal Identification Number (PIN) if known
Payee Name for the New Check	
Street Address of the Person Making This Claim	

City	State	Zip Code

Signatures Must be Notarized

*Signature of person making the claim for reissuance of a stale-dated check.	If more than one person, signature of other person making the claim for reissuance of a stale-dated check.
Print Name	Print Name
Notarization is Required Subscribed and affirmed to me This _____ day of _____, _____ _____ Signature of Notary Public State of _____ My Commission (is permanent) _____ OR Expires _____	**Place Seal Here**

Send this document to the address provided in the upper left-hand corner of this document. Check replacement will take 3 weeks.

*If the payee is deceased, the person making the claim on behalf of the payee's estate should complete this form as completely as possible and attach a letter explaining that they are acting on behalf of the estate. Attach notarized copies of your appointment or authorization to act in this capacity.

Instructions

Payee Name on the Original Check
Please insert the name of the person named on the check you are asking a reissuance for. This may be you or someone else.

Claimant (Your) Telephone Number
Please insert *your* telephone number here. You are the claimant. This may be the person named on the check or someone else.

Payee Social Security Number
This is the social security number of the person named on the check. This may be you or someone else. The provision of your Social Security number is mandatory under Section 466(a) (42U.S.C.666(a)). Your Social Security number will be used for identification purposes. If you do not provide your Social Security number, your application will be denied.

KIDS Personal Identification Number (PIN) if Known
This is the PIN (as assigned in the KIDS child support system) of the person for whom the check was written, the person named on the check.

Street Address of the Person Making This Claim
This is where the check will be mailed if your claim is approved. This may be the address of the person named on the check or someone else. If it is not the address of the person named on the check, please attach an explanation.

City, State, and Zip Code
Please provide these as part of the street address above.

Signature of Person Making the Claim for Reissuance of a Stale-Dated Check
This is the signature of the person making the claim for the check. It may or may not be the person named on the check. It is the signature that must be notarized. If it is not the person named on the check, please attach an explanation. If the person making this claim is acting on behalf of the payee's estate, then you must attach notarized copies of your authorization to act in this capacity. If the form is not properly notarized, it cannot be processed.

If more than one person, please provide the signature of the other person making a claim for reissuance of a stale-dated check
If more than one person is making the claim for reissuance of a stale-dated check (For example: if the claim is part of an estate that is jointly administered), please provide the second person's signature here. This signature must also be notarized.

Print Name
Please carefully and clearly print your name(s) in the boxes provided.

DCF is an equal opportunity employer and service provider. If you have a disability and need to access this information in an alternate format, or need it translated to another language, please contact (608) 266-9909 or (800) 947-3529 WTRS TTY (Toll Free).