**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Management Services

**Write-off / Adjustment Form**

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| **TO: Public Assistance Collection Section**  **P.O. Box 8938**  **Madison, WI 53708-8938**  **Fax: 608-422-7152 / Email: dwspacu@wisconsin.gov** | | Date Submitted |
| **Section 1** *(instructions on reverse side)* | From: Agency Name | Telephone Number  (   )    - |
| Agency Contact Name | Agency Contact E-mail |
| Liable Individual(s) | PIN(s) |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Claim Number** | **Assistance Program** | | **Error Type** | **Original Claim Amount** | **Adjusted Claim Amount** | **Write-off / Adjustment** | **Claim Amount After Adjustment** | **Amount of Adjustment** | |  |  | |  |  |  |  |  | $ 0.00 | |  |  | |  |  |  |  |  | $ 0.00 | |  |  | |  |  |  |  |  | $ 0.00 | |  |  | |  |  |  |  |  | $ 0.00 | |  |  | |  |  |  |  |  | $ 0.00 | |  |  | |  |  |  |  |  | $ 0.00 | |  | | **Total** | | $ 0.00 | $ 0.00 |  | $ 0.00 | $ 0.00 | | |

**Explanation**

|  |  |
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| **Section 2** *(instructions on reverse side)* | Explanation for Request: |

**Reason / Justification for Write off / Adjustment (Check All Conditions That Apply)**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 3** (instructions on reverse side) | |  |  | | --- | --- | |  |  | |  |  | |  |  | |  |  | |  |  | |

**RETAIN COMPLETED FORM IN CASE RECORD**

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| **Section 1 Instructions** | Date: Date forwarded to Public Assistance Collection Section.  From: Agency Complete Name.  Agency Contact Name — Individual completing this form.  Agency Contact Email – Individual’s email address who is completing this form.  Agency Telephone—agency contact’s telephone number.  Liable Individual: List all liable individuals where a write off or adjustment impacts the individual. (In bankruptcy if only one individual files and there are 2 liable individuals, list only the individual where the write off or adjustment should occur.)  PIN(s): List the auto generated Personal Identification Number of the liable individuals.  Claim Number: List the claim number assigned to the overpayment to be written off or adjusted.  Assistance Program: List the category of assistance for the overpayment to be written off or adjusted.  Error Type: List the error type of the overpayment to be written off or adjusted.  Original Claim Amount: Amount of the claim as it was first created prior to any adjustments  Adjusted Claim Amount: Amount of the claim after all **previous** adjustments have been made. Complete only when an adjustment has been previously concluded on the claim.  Write-off / Adjustment Checkbox: Select whether the claim is to be Written off or adjusted.  Claim Amount After Adjustment: What amount the claim should be adjusted to.  Amount of Adjustment: Auto Calculated amount that has been adjusted or written off for each claim.  Calculate Button: Selectable tool used to calculate the Amount of Adjustment and the Fields in the ‘Totals’ row.  Totals: Auto Calculated sum of all columns. | |
| **Section 2 Instructions** | Explain in det Explain in detail the justification for the write-off/adjustment request. Attach additional supporting documentation where appropriate. If the original claim amount was recalculated, please include copies of new worksheets and notices with this form. | |
| **Section 3 Instructions** | Reason/Justification for Write-off/Adjustment: Check all conditions that apply.  Where other conditions apply, a detailed explanation is necessary:   * Attach supporting documentation to support the reason/justification. * **The request will be returned to an agency if not properly completed or if supporting documentation does not exist.** | |
| PLEASE SIGN BELOW | | |
| **Agency Requestor: *(Name and Title)*** | | **Date Signed** |

**RETAIN COMPLETED FORM IN CASE RECORD**