**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].

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| **Section A: Provider Information** |
| Provider Number      | Location      | FIS Provider ID      |
| **Section B: Repayment Amounts** |
| Clearly identify each child, the month and year the child care funds were intended for, and the amount you are returning. Each payment received is for a specific month and should be clearly identified in the chart below. Do not combine amounts for multiple children or months on one line. |
| Case Number      | Child Name      | Returned Funds for Month/Year      | Amount Returned      |
| Case Number      | Child Name      | Returned Funds for Month/Year      | Amount Returned      |
| Case Number      | Child Name      | Returned Funds for Month/Year      | Amount Returned      |
| Case Number      | Child Name      | Returned Funds for Month/Year      | Amount Returned      |
| Case Number      | Child Name      | Returned Funds for Month/Year      | Amount Returned      |
| Case Number      | Child Name      | Returned Funds for Month/Year      | Amount Returned      |
| **Section C: Reason(s) for the Voluntary Repayment(s)** |
| [ ]  Payment Made to the Incorrect Provider or Location | [ ]  Child Not Attending for 30 Calendar Days or More |
| [ ]  Received Funds in Error | [ ]  Provider Refuses to Care for Child or Disenrolls Child |
| [ ]  Parent Ineligible for Funds Paid | [ ]  Provider Closure |
| [ ]  Duplicate Issuance | [ ]  Prevent Potential Overpayment Sanction |
| [ ]  Provider Business Decision | [ ]  Parent paid more than the cost of child care |
| [ ]  Registration Fee | [ ]  Other |
| **Section D: Attestation** |
| Carefully read all statements and check “Yes” or “No” to indicate your consent for the following: |
|  | **Yes** | **No** |  |
| 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 identified above. |
| 2. | [ ]  | [ ]  | I understand that the amount indicated 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 that I may be liable for the unreturned funds and an additional fee of $.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      |
| Please return this completed form to your tribal or local Wisconsin Shares authorizing agency via email, fax, or mail to childcare@wisconsin.gov or 201 W. Washington Ave Madison, WI 53703. |