**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)      |
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| **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 |

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**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) |

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**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.**
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| PLEASE SIGN BELOW |
| **Agency Requestor: *(Name and Title)***      | **Date Signed**      |

**RETAIN COMPLETED FORM IN CASE RECORD**