**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Management Services

**REQUEST FOR:** **[ ]  Write-off or** **[ ]  Adjustment (Check one)**

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| **TO: Public Assistance Collection Unit** **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(   )    -     |
|  | Contact Agency Name      |
|  | Liable Individual      | PIN      |
|  | Claim Numbers | Program of Assistance | Error Type | Original Claim Amount | Adjusted Claim Amount | Amount Claim Adjusted To | [ ]  Write-off[ ]  Adjustment Amount |
|  |       |       |     |       |       |       |       |
|  |       |       |     |       |       |       |       |
|  |       |       |     |       |       |       |       |
|  |       |       |     |       |       |       |       |
|  | **Totals** |       |       |       |       |

**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) | **[ ]** Deceased (Documentation Attached) [ ]  Other (Explain in detail and attached supporting[ ]  Duplicate claim – Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_ documentation)[ ]  Bankrupt (Documentation Attached) [ ]  Inadequate records to substantiate the claim**[ ]**  Invalid Claim/Invalid Amount [ ]  W2 Fact Finding Decision (Copy Attached) **[ ]** Fair Hearing Decision (Copy Attached) |

DCF-F-140-E (N. 06/2009) **RETAIN COMPLETED FORM IN CASE RECORD**

**Request for: Check Write-off *or* Adjustment *(not both).***

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| **Section 1 Instructions** |  Date: Date forwarded to Public Assistance Collection Unit. From: Agency Complete Name Agency Contact—Individual 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 Number: List the CARES generated number of liable individuals. Claim Numbers: List the CARES claim number assigned to the overpayment to be written off or adjusted. Program of Assistance: 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 claim appearing on BVCD under the original claim amount field. Adjusted Claim Amount: Amount of claim appearing on BVCD under the adjusted claim amount field. Complete only when an adjustment has been previously concluded on the claim. Amount Claim Adjusted To: What amount the claim should be. Write-off or Adjustment Amount: Difference between adjusted Claim Amount or original claim amount and AMT claim adjusted to. (B-C=D or if no amount in column B A-C=D) Totals: 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:* Agencies requesting a write off for inadequate records should have a letter from agency director explaining why the documentation no longer exists.
* 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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| Worker Approved for Local Agency *(Name and Title)* | Agency Director |
| PLEASE SIGN BELOW |
| **DCF Reviewer Signature** |
| **Approver Signature** | **Date Signed** |
| Comments |
| **Write-off Processor Signature** | **Date Signed** |
| **Auditor Signature** | **Date Signed** |
| **>$5,000 Approver Signature** | **Date Signed** |
|  |