**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Management Services

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |
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|  | **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. | | |
| 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** |
|  | | | |