State of Illinois
Department of Human Services

Stop Payment Request and Recovery Agreement

Facts surrounding missing check:

I did not sign the missing check. I have furnished all information available to me about the missing check. The information I gave is full, complete, and correct to the best of my knowledge and belief. I want the Department to order a stop payment against the check. I want the Department to help me get reimbursement for this check. I will immediately notify the Department if the original check comes into my possession or control and I will return it immediately. I agree not to sign it or cash it. I authorize the Department (or its employees) to deduct from future benefits the amount of the check, if any investigation reveals that I received and cashed the original check.

Payee Signature: _____ Date: _____
(Or witness, if payee unable to sign)

Caseworker Signature: _____ Date: _____
(Or Department representative)

I did not receive the missing check.

Provider Signature: (if needed) _____ Date: _____

Caseworker Signature: _____ Date: _____

Check Information

Date Issued: _____ Check Number: _____ Amount: _____

Type of Check

☐ Regular roll check ☐ Other mercury check ☐ IV-D check ☐ Commercial check
☐ Protective payee check ☐ Pass through check ☐ Supportive service check

Payee Name: _____ Corrected Address: (if different)

Address:

☐ Check this box if this is a provider

Case Name: _____ Case Number: _____
(if different)

Local Office Use Only

Replacement action: ☐ yes Date: _____ ☐ no

Local office name: _____

Address: _____

_____

Print Form Reset Form

Springfield Office Use Only

☐ Stop ☐ Void ☐ Paid