CHILDCARE AND PARENT SERVICES REPORT OF CLAIM DETERMINATION

County Name/No: ______________________ Case Manager: ______________________

Client Name: ______________________ Address: ______________________

Client SSN: ______________________ ______________________

Case Number: ______________________

Provider Name: ______________________ Address: ______________________

Prov. Number: ______________________ ______________________

Prov. SSN/FeID: ______________________

Claim Type	Type of Error	
Overpayment	AE (Administrative Error)	PE (Provider Error)
Underpayment	CE (Client Error)	PV (Program Violation)

Amount Due: ______________________

From	Client
To	Provider

The method of recoupment is:

Lumpsum (full amount) of overpayment

Offset by half of future monthly reimbursements

Monthly payment of __________

Exception (please attach documentation)

Summary of Circumstances:

The reason(s) for the actions taken is:

Signatures: CAPS Staff ______________________ Date: ______________________

Supervisor: ______________________ Date: ______________________

If PV: Investigator's Signature: ______________________

Date of Discovery: ______________________

Completion Date: ______________________

This is authorization to offset __________ from this client/provider.

Copies to: Case Record or Provider File, DECAL Office of Financial Services