



Payment Department
 1515 N. Courthouse Rd, 3rd Floor
 Arlington, VA 22201
 Phone: 1-800-793-0324 Ext. 365
 Fax: 703-341-4199

PROVIDER'S REQUEST FOR CHECK STOP PAYMENT/REISSUE

There is a required period of fifteen (15) business days from check's issue date before stop payment can be placed.

Provider: Please review all information below. Cross out any errors and print correct information.

PROVIDER'S NAME AS IT APPEARS ON CHECK:

PROVIDER'S SOCIAL SECURITY OR FEDERAL I.D. NUMBER:

PROVIDER OR CONTACT NAME AND TELEPHONE NUMBER:

PROVIDER MAILING ADDRESS:

KT:

CHECK DATE:

COVERING CARE FOR MONTH(S) OF:

AMOUNT:

BRANCH OF SERVICE:

REASON FOR CHECK STOP PAYMENT/RE-ISSUE REQUEST:

- Non-receipt of check (mailed to correct address)
- Non-receipt of check (mailed to incorrect address)
- Check misplaced by payee
- Check stolen
- Refer to maker
- Payment was direct deposit (did not receive funds)

I have reviewed and agree with all information referenced above. I understand that if I receive or find the above referenced check after submitting this request, I must not cash it but must forward it immediately to Child Care Aware® of America. I also understand that if I do cash the check after submitting the request, I may be held responsible for remitting any overpayments and/or paying for any bank fees incurred because of doing so.

 (Print Name)

 (Provider's Signature)

 (Date)

Please return this form via e-mail to stoppay@usa.childcareaware.org
 or fax to 703-341-4199