Department of Health and Social Services
Division of Public Assistance

# STOP PAYMENT AFFIDAVIT

DPA Office: _____ Address: _____

**Once this form is completed and signed, the stop payment process has begun and will not be stopped.**

**Request Stop Payment on State of Alaska Warrant # _____**

**Date Issued:** _____

**Amount:** _____

**Program:** _____

**Case Number:** _____

**Payee Name:** _____

**Mailing Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**REASON FOR REQUEST: Above numbered warrant (please check one)**

☐ **Lost** ☐ **Stolen** ☐ **Undelivered** ☐ **Destroyed**

**PAYEE:** **Should I receive the above numbered warrant after completion of this affidavit, IT CANNOT BE CASHED, and will not be honored by the State of Alaska. If I do receive warrant # _____, I am agreeing to return it immediately to the Public Assistance Office address at the top of this form. I further understand that should I later receive and cash the original warrant, this will represent double payment of benefits and I will be liable for the overpayment.**

**PAYEE Signature:** _____ **Date:** _____