WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-19002 (08/2023)

EBT

REQUEST TO REDUCE QUEST CARD BALANCE

FoodShare members may use this form to:

- Request a one-time payment from their QUEST card to repay a FoodShare overpayment.
- Request unused or unwanted FoodShare benefits be returned to the FoodShare program.

INSTRUCTIONS: Fill out Section 1 and submit this form to your agency. You will get a copy of the completed form after your payment is made. This form is voluntary and may be used for a one-time request to reduce your QUEST card balance. You may cancel this request in writing any time prior to the payment date you enter below.

SECTION 1 – MEMBER INFORMATION

Name – Member			Case Number
Street Address			Apartment / Unit Number
City	State	Zip Code	Phone Number

I authorize my QUEST card to be used for the following (check one):

☐ Repay a FoodShare overpayment

☐ Return unused or unwanted FoodShare benefits to the FoodShare program

Reduce my QUEST card in the amount of $ _____ on _____ (mm/dd/yyyy).

SIGNATURE – Member	Date Signed

FOR AGENCY USE ONLY
Only the agency or the Office of the Inspector General can process this request.
The Public Assistance Collection Unit cannot process this request.

SECTION 2 – PHONE REQUEST TO AGENCY STAFF PERSON

INSTRUCTIONS FOR WORKER:

1. Fill out Section 1, except for the member's signature.
2. Complete this section.

The above-named member has made an oral phone request to the agency staff person below to use the member's QUEST card for the reason checked above.

SIGNATURE – Agency Staff	Date Signed
Print Name of Agency Staff	Worker ID

EBT

SECTION 3 – QUEST CARD RECEIPT

INSTRUCTIONS FOR WORKER:
1. Fill out this section when the request has been processed.
2. Mail a copy of this form to the member.
3. Scan the form into the member's electronic case file (ECF).

Date Completed	

Description (FoodShare Overpayment Claim Number if applicable)	**Amount**	**Remaining FoodShare Overpayment Claim Balance (if applicable)**
	$	$
	$	$
	$	$
Total Amount Taken From QUEST Card	$	

I hereby certify that the requested dollar amount was taken from the member's QUEST card and that the funds were applied to the claim(s) listed above (if applicable).

SIGNATURE – Agency Staff	Title	Date Signed

RESET FORM

USDA NONDISCRMINATION STATEMENT
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In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

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