



STATE OF MISSOURI  
DEPARTMENT OF SOCIAL SERVICES  
**AFFIDAVIT FOR REPLACEMENT CHECK**

CLAIMANT NAME		COUNTY OF RESIDENCE
DATE OF CHECK	CHECK NUMBER	AMOUNT OF CHECK
NAME OR NAMES ON CHECK (PAYABLE TO)		
DIVISION CONTACT NAME		DIVISION CONTACT TELEPHONE NUMBER, INCLUDING EXTENSION

I, the above named claimant, state the following: The

check identified above has: (check one)

- never received
- been destroyed;
- been received, but was lost;
- other \_\_\_\_\_

In addition, I state I have never received the dollar amount of the check or any portion of it either directly or indirectly.

Further, I know that it is a violation of the criminal law of the State of Missouri to knowingly make a false affidavit for the purpose of procuring a replacement check for a lost or destroyed check or to negotiate the original state check for which I have caused a replacement check to be issued.

Further, I state that if a replacement check is issued to replace the lost original state check and the original check is then found, the original check will be mailed directly to the Division of Finance and Administrative Services.

I want my replacement check to be mailed to (check one):.

- The Family Support Division\Children's Division office in the county where I live.
- My home address which I have written below. If I did not complete the home address, the replacement check will be mailed to the office in the county where I live.

<b>MUST BE SIGNED IN PRESENCE OF NOTARY</b>	CLAIMANT SIGNATURE	DCN NO. OR DVN NO.

ADDRESS (STREET, CITY, STATE, ZIP)

NOTARY PUBLIC EMBOSSE OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS	
	DAY OF	YEAR
	<b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	