Mississippi Department of Human Services  
Division of Budgets & Accounting

LOST WARRANT REPLACEMENT REQUEST

The State Treasurer’s Office STOP PAYMENT REQUEST form and the original LOST WARRANT REPLACEMENT REQUEST for must be sent directly to the STATE TREASURER’S OFFICE prior to the replacement of any lost warrant.

AFFIDAVIT FOR REPLACEMENT OF LOST WARRANT

Warrant Number ____________________  Original Issue Date ____________________
Warrant Amount $ ___________  SAAS Vendor Number ___________
Payee Name ____________________________________________________________

As the Payee, Authorized Payee’s Representative or Agency Representative having knowledge of the facts I certify that the above referenced warrant has been lost or destroyed and requested that a replacement warrant be issued.

Printed Name __________________________________ Signature ____________________

THE STATE OF ___________________________  COUNTY OF ___________________________
TOWN OF ___________________________

Personally came and appeared before me, the undersigned authority in the jurisdiction aforesaid, the within named ____________________, who after first being placed on his/her oath, and having been established as a credible person with knowledge, did state that the matters contained within the above and forgoing Affidavit are true and correct as therein stated.

Sworn to and subscribed before me, on this the ______ day of ___________________________, 2__________

Commission Expiration Date ________ Notary Public ________

Agency Name _____________________________________________________________
Contact Name __________________________ Phone Number __________________________
Email Address _____________________________________________________________
REQUEST FOR DUPLICATE CHECK

Personally appeared before me the undersigned authority in and for said county of ______________________ and State of ______________________ who, on oath, states the following facts to wit: I, ______________________________, state as a fact under oath that the check for the Child Care Payments:

☐ Has never been received, endorsed or cashed by me.
☐ Was received but has been lost, misplaced or stolen and I have not personally benefited whatsoever by the receipt of said check or the proceeds from same.

I further state, on oath, that ☐ I did, ☐ I did not endorse the check.

PAYABLE TO: __________________________

Whose present complete Mailing address is: __________________________

County: _________________ Co. No. ____________

Case/Provider No. _________ Date of Check: _______

FOR STATE OFFICE USE

Original Check Number $ ____________

Duplicate Check Number $ ____________

Date Employee

Verified as correct

Check not in file as of

Mailed duplicate check

Original Check Number

Duplicate Check Number

Date

Employee

I hereby further state an oath that because of the foregoing facts I hereby make formal request for the issuance of a duplicate of the above described check with the understanding that I shall be PERSONALLY RESPONSIBLE for the original check described above should proof satisfactory to the law enforcing agencies of the above named county and state and/or by the Mississippi Department of Human Services (MDHS) be developed that representations, under oath, made by me herein are not true; I hereby state further on oath and hereby pledge myself to protect the state against any loss should the original check be paid and should the duplicate check herein applied for be also issued and paid because of any misrepresentation, under oath, on my part; and I further pledge that I will give full cooperation to the law enforcement authorities of the above named county and state as well as to MDHS in the prosecution of any person who obtained my check or aided or abetted any other person to obtain my check unlawfully.

Additional remarks of CLAIMANT: __________________________________________________________

________________________ __________________________

Signed (Mark) DATE

Witness Witness:

Personally appeared before me the foregoing ____________________________ who expresses and says that the above statements are true and correct to the best of his or her knowledge and belief, who signed the above statement in my presence.

________________________ __________________________

Signed (NOTARY PUBLIC) (DATE)

☐ I recommend issuance of a duplicate check. Signed ____________________________

☐ I do not recommend issuance of duplicate check. (See attached) (DECCD DIRECTOR)