FAMILY SUPPORT SERVICE REIMBURSEMENT REQUEST

Williams County Board of DD

Date: _____ Service Requested: _____

Applicant: _____

Request:
[ ] similar to previously approved (i.e. mileage, personal care needs)
[ ] ongoing for current FY
[ ] new
[ ] *requires Ethic Committee review/approval*

Payment Issued To: _____ Vendor #_____

_____

_____

Total: _____ Family Co-Pay%: _____

Family Responsibility: _____

Requested Payment: _____

Reviewed by FSS Team:	[ ] Yes	[ ] No	Date: _____
Reviewed by Supt:	[ ] Yes	[ ] No	Date: _____
Reviewed by Fin. Comm.	[ ] Yes	[ ] No	Date: _____

Additional Notes: _____

_____

_____

Approval Number: _____

Approved by: _____ Date: _____