SOUTHWESTERN OHIO COUNCIL OF GOVERNMENTS (SWOCOG)
Family Support Services Program - GCBDDS
412 S. East Street
Lebanon, OH 45036
Phone (513) 559-6800 Toll free (877) 423-6900 Fax (855) 763-3050
Sandy.Schutte@swocog.org

2021-REQUEST FOR VOUCHERS FORM

*****VOUCHERS MUST BE REQUESTED BEFORE SERVICE BEGINS*****

PLEASE PRINT ALL INFORMATION

Name of person enrolled _____Today's Date_____

Requesting Family Member: _____Phone_____

Address: _____

City_____Zip Code_____

Please indicate if you would like to have this request handled as a reimbursement Yes_____ No____
(W9 form must be on file for the parent/guardian for family reimbursement)

RESPITE CARE

(A completed provider application, W9 form, & family waiver must be on file.)

Provider/Vendor's Name	Number of vouchers needed	Amount $ needed per voucher
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER

Provider/Vendor's Name	Number of vouchers needed	Amount $ needed per voucher
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Parent/Guardian _____ Date_____

OVER

The mission of the Southwestern Ohio Council of Governments is to provide support and solutions to county boards of developmental disabilities through cost-effective shared services that deliver value, satisfaction, and maximization of resources.

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Name of person enrolled _____Today's Date_____

Requesting Family Member: _____Phone_____

THERAPY, COUNSELING, TRAINING, EDUCATION
(A doctor's or therapist's recommendation for this service must be on file from last year.)
If you do not have one on file, you must complete the Verification of Need form before we can issue vouchers.

Provider/Vendor's Name	Number of vouchers needed	Amount $ needed per voucher
_____	_____	_____
_____	_____	_____
_____	_____	_____

DIAPERS age 3 and older
(A doctor's or therapist's recommendation for this service must be on file from last year.)
If you do not have one on file, you must complete the Verification of Need form before we can issue vouchers.

Provider/Vendor's Name	Number of vouchers needed	Amount $ needed per voucher
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIAL DIETS/SUPPLEMENTS
(A doctor's or therapist's recommendation for this service must be submitted <u>each year</u> before we can issue vouchers)

Provider/Vendor's Name	Number of vouchers needed	Amount $ needed per voucher
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Parent/Guardian _____ Date_____

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