2025-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.

Name of person enrolled _____Today's Date_____

Requesting Family Member: _____Phone_____

THERAPY, COUNSELING, TRAINING, EDUCATION, ACTIVITIES
(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 submit one with this 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 submit one with this 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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