

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

2024-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)**

RESPIRE CARE

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

<u>Provider/Vendor's Name</u>	<u>Number of vouchers needed</u>	<u>Amount \$ needed per voucher</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER

<u>Provider/Vendor's Name</u>	<u>Number of vouchers needed</u>	<u>Amount \$ needed per voucher</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____

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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.

<u>Provider/Vendor's Name</u>	<u>Number of vouchers needed</u>	<u>Amount \$ needed per voucher</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

<u>Provider/Vendor's Name</u>	<u>Number of vouchers needed</u>	<u>Amount \$ needed per voucher</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIAL DIETS/SUPPLEMENTS

(A doctor's or therapist's recommendation for this service must be submitted each year before we can issue vouchers)

<u>Provider/Vendor's Name</u>	<u>Number of vouchers needed</u>	<u>Amount \$ needed per voucher</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Parent/Guardian _____ Date _____