

**SOUTHWESTERN OHIO COUNCIL OF GOVERNMENTS (SWOCOG)**

**Family Support Services Program - GCBDDS**

**412 S. East Street**

**Lebanon, OH 45086**

**Phone (513) 559-6800 Toll free (877) 423-6900 Fax (855) 763-3050**

**Sandy.Schutte@swocog.org**

**2026-REQUEST FOR VOUCHERS FORM**

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

**Email, fax, or mail back to the office once completed**

Name of person enrolled \_\_\_\_\_

Requesting Family Member: \_\_\_\_\_

Phone \_\_\_\_\_ Email address \_\_\_\_\_

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, THERAPY, COUNSELING, ACTIVITIES**

**(A completed provider application, W9 form, & family waiver must be on file for respite care)**

**(A doctor/therapist's recommendation must be on file from last year for therapy, counseling, and activities.**

**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/therapist's recommendation must be on file from last year for diapers)**

Provider/Vendor's Name

Number of vouchers needed

Amount \$ needed per voucher

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SPECIAL DIETS/SUPPLEMENTS**

**(A doctor/therapist's recommendation must be submitted each year before we can issue vouchers for special diets)**  
**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

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