

**Self-Directed Services**  
**Reimbursement Form/Check Request**

Name of Participant: \_\_\_\_\_ Receipt Date: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

Name of Staff: \_\_\_\_\_

Please Attach Receipt(s) below

Mail form to:      Attn:      **Judy Peck**  
50 Farnum Street  
Wellsville, NY 14895  
(585) 593-5700 ext. 543

**Valued Outcome:**

**How is service/activity related to the valued outcome(s)?**

**Who should be reimbursed?**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

**I have reviewed and give consent for the reimbursement for this expenditure as reflected in my SDS budget.**

**Participant/Representative signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please submit original, signed form with attached receipt to the SDS Dept. at 50 Farnum Street location, along with your timesheets on a weekly basis (as applicable).**