

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).