



Wisconsin's Self-Directed Supports Program

Check Request

Medicaid ID number: _____

Item purchase or service end date: ____ / ____ / 20 ____

Pay For:

Participant name (please print): _____

Phone number: ____ - ____ - _____

Pay To:

Vendor or participant name (please print): _____

Address (if vendor): _____

Description of provided goods or services: _____

Service code ____

Unit Type: _____ (each, hour, day, etc.)

Unit rate: \$_____ Number of units: _____ Amount: \$_____

Mail to: Participant Vendor

Approved:

_____ Date: ____ / ____ / 20 ____

(Participant / Participant's representative signature)

You must attach a receipt, invoice or bill to receive payment. Reimbursement amounts should *not* exceed \$300.
