Lucas County Board of Developmental Disabilities

RECEIPT REIMBURSEMENT

Lucas County Family Support Services Program
Funded by Lucas County Board of Developmental Disabilities

The funds are not guaranteed and need to be submitted **within 30 days of service/purchase.**

1. Attach receipt to the back of this form, with the items that are being requested for reimbursement underlined on the receipt.

2. Please list receipt totals.

_____
_____
_____
_____
_____
_____
_____
_____

3. Fill in the **Consumer Name** (your eligible family member's name) and "Issue reimbursement check to", including **full name, mailing address, and phone**.

Consumer Name _____

Issue Reimbursement Check to:

Allow 45 days from date of submission for payment

Name _____
Address _____
City _____ State ____ Zip _____
Phone _____
Email _____

OFFICE USE ONLY
Co-pay _____
Contract # _____
Amount $ _____
☐ Approved ☐ Denied
Date _____
CT___ SD___ AE___ HM___ DE___ OT___

Total cost of services is reimbursed within the current funding limit and in accordance withe the family's taxable income level. The funds are not guaranteed and requests need to be **submitted within 30 days of service/ purchase**; all vouchers **must** be postmarked by December 8. Items must be reimbursed in the fiscal year they were purchased.

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C/O Lucas County Board of Developmental Disabilities
1932 Birchwood
Toledo OH 43614