|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01264 (06/2017) | | | |  | | **STATE OF WISCONSIN** | | | |
| **SERVICE FUND APPLICATION FOR REIMBURSEMENT** | | | | | | | | | |
| **Directions:** | Organizations please complete Section 1 only.  Deaf and Hard of Hearing people please complete Section 2 only.  Send completed form as indicated below **TWO WEEKS PRIOR TO THE EVENT**. | | | | | | | | |
| **For More Information about Service Fund Requirements go to:** [http://www.dhs.wisconsin.gov/odhh/ServiceFund](http://www.dhs.wisconsin.gov/odhh/ServiceFund/index.htm) | | | | | | | | | |
| **SECTION 1 – ORGANIZATIONS OR AGENCIES** | | | | | | | | | |
| Applicant’s Full Name | | | | Agency/Organization Name | | | | | |
|  | | | |  | | | | | |
| If Affiliated with a Parent Organization – List Name | | | | | | | | | |
|  | | | | | | | | | |
| Street Address | | | | City | | | | State | Zip Code |
|  | | | |  | | | | WI |  |
| Contact Phone Number | | Contact Email Address | | | | | | | |
| -     - | |  | | | | | | | |
| List Service(s) Your Agency/Organization Provides | | | | | | | | | |
|  | | | | | | | | | |
| Reason You are Requesting Financial Assistance | | | | | | | | | |
|  | | | | | | | | | |
| Financial Structure of Your Organization (i.e., justification of an undue hardship) | | | | | | | | | |
|  | | | | | | | | | |
| List Brief Description of Service You are Providing for the Deaf or Hard of Hearing Consumer(s) | | | | | | | | | |
|  | | | | | | | | | |
| Service(s) Being Provided | | | Date | | Time | | Location | | |
|  | | |  | |  | |  | | |
| Type of Service You are Requesting (e.g., two interpreters for eight hours) | | | | | | | | | |
|  | | | | | | | | | |
| Cost Estimate for the Service | | | | | | | | | |
|  | | | | | | | | | |
| **SECTION 2 – DEAF & HARD OF HEARING CONSUMERS** | | | | | | | | | |
| Applicant’s Full Name | | | | | | | Applicant’s Phone number | | |
|  | | | | | | |  | | |
| Applicant’s Email Address | | | | | | | | | |
|  | | | | | | | | | |
| Reason for Interpreter/CART/SSP | | | | | | | | | |
|  | | | | | | | | | |
| Date | | | Time | | | | | | |
|  | | |  | | | | | | |
| Information contained in email messages may be privileged and confidential. There is some risk that any information in an email you send may be disclosed to, or intercepted by, unauthorized third parties. By agreeing to allow the use of email as a method of communication to WI DHS, this indicates that you acknowledge and accept the possible risks associated with such communication. | | | | | | | | | |
| **Save completed form and then click email link below and attach the saved form as an attachment and send.** | | | | | | | | | |
| **Email or fax your request to:** | | | | | | | | | |
| Bette Mentz-Powell  [Bette.MentzPowell@Wisconsin.gov](mailto:Bette.MentzPowell@Wisconsin.gov?subject=Service%20Fund%20Application)  Fax: 608-264-9899 | | | | | | | | | |
| **For requests in writing, please send to:** | | | | | | | | | |
| Department of Health Services Office for the Deaf and Hard of Hearing  c/o Service Fund  PO Box 2659  Madison, WI 53701-2659 | | | | | | | | | |