DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-01264 (08/2024)

STATE OF WISCONSIN

SERVICE FUND APPLICATION

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

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:

Steve Smart
steven.smart@dhs.wisconsin.gov
Fax: 608-224-5754

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