

TUBERCULOSIS (TB) TREATMENT ASSISTANCE PROGRAM - SPECIAL REQUEST

Exceedance of \$50 LTBI Cap or \$200 Active TB Cap

Agency Name	Contact Person - Name
Contact Email	Contact Phone
Agency Address (where reimbursement will be sent)	

Please describe the special request for TB treatment assistance below (including WEDSS Incident ID):		Amount Requested	Approve/Decline Initials
<input type="checkbox"/>	Rent Assistance: Dates or month of rental assistance: WEDSS Incident ID:		
<input type="checkbox"/>	Other Housing Assistance: Dates or month of housing assistance: WEDSS Incident ID:		
<input type="checkbox"/>	Utility Payment: Dates or month of utility assistance: WEDSS Incident ID:		
<input type="checkbox"/>	Phone service payment: Dates or month of phone service assistance: WEDSS Incident ID:		
<input type="checkbox"/>	Other request: Dates or month of assistance: WEDSS Incident ID:		
TOTAL AMOUNT REQUESTED			

SIGNATURE - Contact

 Date Signed

Wisconsin Department of Health Services
 TB Treatment Assistance Program
 Phone: 608-261-6319
 Fax: 608-266-0049
 Email: DHSWITBProgram@dhs.wisconsin.gov