

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: Incident ID - Dates or month of rental assistance: _____ Description/Reason: _____		
<input type="checkbox"/> Other Housing Assistance: Incident ID - Dates or month of housing assistance: _____ Description/Reason: _____		
<input type="checkbox"/> Utility Payment: Incident ID - Dates or month of utility assistance: _____ Description/Reason: _____		
<input type="checkbox"/> Phone service payment: Incident ID - Dates or month of phone service assistance: _____ Description/Reason: _____		
<input type="checkbox"/> Other request: Incident ID - Dates or month of assistance: _____ Description/Reason: _____		
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