



OREGON
 VETERAN DIRECTED CARE
 REIMBURSEMENT CHECK REQUEST

Instructions: Please complete the form below and attach **back-up documentation and receipt(s)** as needed. The Veteran/Employer of Record must sign the form. If the reimbursement is being made to a worker, that worker's signature is also required. Please sign and date at the bottom and submit the completed form to **ResilientSD**.

Mail
 10425 W. North Ave
 Suite 345
 Milwaukee, WI 53226

Email
Enrollment@Resilient-SD.com

VETERAN INFORMATION

Name: _____ Last 4 Digits of SSN: _____

Make check payable to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Check this box **ONLY** if you **DO NOT** want the check to be mailed to the vendor.

| Date of Invoice | Service Code | Description of Service | Unit | Quantity | Rate | Amount |
|-----------------|--------------|------------------------|------|----------|------|--------|
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REMINDER: Please attach a copy of the receipt, invoice, or other documentation confirming the amount of purchase.

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____