

**WI Seal-a-Smile**  
**Invoice/Reimbursement Request 2011-12**

Please fax this request form to:  
Matt Crespin, Project Manager  
Children's Health Alliance of WI  
(414) 392-4002, telephone  
[mcrespin@chw.org](mailto:mcrespin@chw.org)  
(414) 231-4972, fax

**Date of Invoice:** \_\_\_\_\_

**Sealant Program Name:** \_\_\_\_\_

**Fiscal Agency/Organization:** \*Checks will be made out to this entity unless otherwise noted.

\_\_\_\_\_

**Fiscal Agent Contact person (Program Director):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Total Amount of Invoice/Reimbursement Request: \$** \_\_\_\_\_

Please itemize your request in the space below.

**Personnel: \$**

Itemize expenditures (name, title, FTE, rate of pay, fringes)

**Supplies: \$**

\*Include copy of invoice/receipt

**Equipment: \$**

\*Include copy of invoice/receipt

**Other—Specify: \$**

**Subcontracted Services: \$**

**Rate of payment:    Hours of service:**

\*Include name and contact information of each subcontractor receiving payment for services.

Signature of Fiscal Agent Representative: \_\_\_\_\_

Date: \_\_\_\_\_