WI Seal-a-Smile
Invoice/Reimbursement Request 2008-09

Please fax this request form to:
Matt Crespin, Project Manager
Children's Health Alliance of WI
(414) 292-4002, telephone
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: _______________