EEDA Family Reimbursement Program
Receipt of Payment - SDS

Individual's Name: _____ Medicaid #:_____

Family Name: _____

Month _____ Year _____

Address: _____

_____

DATE	Start Time	End Time	HOURS USED	Amount Paid	Parent/Guardian Signature

(*Services may not be provided by a parent or guardian)

Notes/Other: _____

I certify that the information listed above is an accurate record of services provided and this document is the receipt for payments I made for these services.

Name (print): _____

Signature: _____

Date: _____