OUTREACH HEALTH SERVICES
Caring Since 1975

Participant-Hired Worker Reimbursement Report

IRIS
Include, Respect, I Self-Direct

INSTRUCTIONS:

1. Please complete expense information and attach receipt.

2. Person seeking reimbursement and participant/employer sign at bottom.

Service Month: _____

Name of Person to be Reimbursed: _____

Print Participant Employer Name: _____

Date	Description	Service Code	Amount
		Total Amount:	$ 0.00

Signature of Person to be Reimbursed: _____ **Date:** _____

Participant Employer or Guardian Signature: _____ **Date:** _____

Phone: 715-494-9440 • Toll-Free Phone: 1-877-901-5826 • Toll Free Fax: 1-800-687-3121
Website: www.outreachhealth.com/wi