



Participant Purchase/Reimbursement Request Form

Return to: ACES\$ Washington *400 Union Avenue SE *Olympia, WA 98501

Fax: 1 (800) 416-1649

Email: GoodServiceWA@mycil.org

Participant Name:
(First,Last)

Designated Representative Name:
(First,Last)

Participant ID:

Vendor Name:

Vendor ID:

Vendor Address:

Street Address

Suite

City

State

Zip Code

Participant Phone Number:

Designated Representative Phone Number:

GOOD/SERVICE DETAILS

Allocation ID:

Date Valid From:

To:

Type of Request:

Purchase (mail check to Participant)

Purchase (mail check to Vendor)

Online Purchase (ACES\$ makes purchase on behalf of Participant)

Reimbursement

If Reimbursement, Date of Purchase:

Invoice ID:

All requests must have a copy of a receipt, invoice or online shopping cart print out.

ONLINE PURCHASE REQUEST DETAIL

ACES\$ to purchase item online directly from Vendor using information below.

Please include a print-out of the online shopping cart with the item details.

Item Name, Brand and Description:

Vendor Website Address:

PURCHASE FREQUENCY

Request For:

One Time Purchase

Cyclical

If Cyclical, Frequency of Purchase:

Weekly

Monthly

Semi-Monthly

Other:

GOOD/SERVICE

Good/Service Type:

Treatment and Health Maintenance

Environmental and Vehicle Modifications

Individual Goods, Services, and Supports

Training and Educational Supports

Item/Service:

Item Total (including tax): \$

My signature certifies that I receive goods and services as part of my plan and that the item requested is authorized. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material facts may be prosecuted under applicable Federal and State laws.

Participant/Designated
Representative Signature:

Date: