



AGING AND LONG-TERM SUPPORT ADMINISTRATION
DEVELOPMENTAL DISABILITIES ADMINISTRATION

Participation Reimbursement

Note: This form must only be used when a client has overpaid participation.

CLIENT NAME		ACES ID NUMBER	ADSA ID NUMBER	DATE
SERVICE WORKER INFORMATION				
AUTHORIZING SERVICE WORKER			TELEPHONE NUMBER	
AUTHORIZING SERVICE WORKER'S SIGNATURE			REPORTING UNIT	
REIMBURSEMENT COMPUTATION FORMAT				
COLUMN A		COLUMN B	COLUMN C	COLUMN D
Proc / Svc Code	Month / Year Services Were Authorized	Wrongfully Paid Participation Amount (Actual Payment has been Verified)	Financial Services Retroactively Corrected Participation Amount	Subtract Column C from Column B. Enter Remainder Below
1				0.00
2				0.00
3				0.00
4				0.00
5				0.00
6				0.00
7				0.00
8				0.00
9				0.00
10				0.00
11				0.00
12				0.00
COLUMN TOTALS		0.00	0.00	0.00
Column B Minus Column C = Total Reimbursement Amount				
Forwarded to supervisor for review to reimburse the client through ProviderOne on _____ . (MONTH / YEAR)				
(Attach verification that payment was made by the client and received by the provider.)				
Supervision Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Denied				
ADDITIONAL COMMENTS				
SUPERVISOR'S (SIGNATURE)				DATE

DSHS 07-081 (REV. 12/2016)

Barcode label



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