



SOCIAL SERVICES BLOCK GRANT

State Form 48203 (2-97) / DHHS 0002

Mail to:
Deaf and Hard of Hearing Services
 Family and Social Services Administration
 Division of Disability, Aging, and Rehabilitative Services
 P.O. Box 7083
 Indianapolis, IN 46207-7083

Service authorization number

Name of vendor

Name of agency / firm / organization		Name of requestor		Telephone number
Address of requestor (<i>number and street, city, state, ZIP code</i>)				
Name of consumer(s)			Situation	
Service date	Date requested		Date confirmed	
Requested service time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. to		Actual service time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. to		Total service time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Site of service address (<i>number and street, city, state, ZIP code</i>)				
Travel from	Travel to		Total miles (<i>round trip</i>)	
Type of service <input type="checkbox"/> Interpreting <input type="checkbox"/> Case management		Name of interpreter(s) or case worker		
County of service				

Signature of authorized vendor representative	Title	Date (<i>month, day, year</i>)
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Administrative instructions or explanations