

Service authorization number

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

Name of vendor					
Name of state agency			Name of requestor		Telephone number
Requestor address (number and street, city, state, ZIP code)					
Name of consumer(s)			Situation		
Service date	Date requested			Date confirmed	
Requested service time		ctual service			Total service time
☐ AM ☐ PM to ☐ Site of service address (number and street, city, state, ZIP co	AM PM Pde)		☐ AM ☐ PM to	☐ AM ☐ PM	
Travel from:	Travel to:			Total miles (round trip)	
Name of Interpreter(s)					
Signature of authorized vendor representative			Title		Date (month, day, year)
Administrative instructions and / or explanations					