



SUPPLEMENTAL BILLING REQUEST

Complete in accordance with Instructions for Completing Billing Information on the Vocational Rehabilitation Plan form when additional funds are needed to complete an existing plan. If there are changes to the Type of Plan, Training/Vocational Goal, or length of the plan another Vocational Rehabilitation Plan must be submitted.

Employee Name: _____ Date of Request: _____
Vocational Rehabilitation Plan Start Date: _____ End Date: _____

Reason for Request: _____

A. TUITION & FEES: **It is understood that costs for tuition & fees are estimated and subject to revision.**
\$ _____ Start Date: _____ End Date: _____
Authorize to: _____
Address: _____
City: _____ State: _____ ZIP: _____

B. REQUIRED BOOKS: **It is understood that required book costs, including sales tax, are estimated and subject to revision.**
\$ _____ Start Date: _____ End Date: _____
Authorize to: _____
Address: _____
City: _____ State: _____ ZIP: _____

C. GENERAL SUPPLIES: **General supplies (e.g., USB flash-drive, pens, pencils, notebooks) \$30.00 per term or semester, in addition to the \$30.00, include sales tax.**
\$ _____ Start Date: _____ End Date: _____
Authorize to: _____
Address: _____
City: _____ State: _____ ZIP: _____

Required Supplies must be supported by documentation. An itemized list must be attached and prior approval must be obtained prior to purchase of these supplies. Include sales tax if applicable.
D. REQUIRED SUPPLIES: \$ _____ Start Date: _____ End Date: _____
Authorize to: _____
Address: _____
City: _____ State: _____ ZIP: _____

Special Fees are costs which may uniquely apply to an individual's plan, but must be reasonable and necessary. Include sales tax if applicable. Prior approval must be obtained.
E. SPECIAL FEES: \$ _____ Start Date: _____ End Date: _____
Authorize to: _____
Address: _____
City: _____ State: _____ ZIP: _____

F. TUTOR INFORMATION & FEES: **Any tutoring services require prior approval. Documentation of the need for tutoring may be requested.**
Start Date: _____ End Date: _____
Hourly Rate: \$ _____ x Hours Per Week: _____ x Number of Weeks: _____ = Total: \$ _____
Authorize to: _____ SSN/FEIN: _____
Address: _____
City: _____ State: _____ ZIP: _____

Requested by: _____ Date: _____ Approved by: _____ Date: _____
Vocational Rehabilitation Counselor/ Certification # WCC Vocational Rehabilitation Specialist