

TB Manager/CHD Nurse _____
Phone# _____
Date _____

INCENTIVE/ENABLER REQUEST FORM

Housing

Date _____ **Approval Signature:** _____

COUNTY HEALTH DEPARTMENT _____

Patient's Name _____ SS# _____

Hotel/Motel/Landlord _____ Property Manager _____

Payment Mailing Address _____ City/State _____ Zip _____

Will vendor accept state VISA card for payment? Yes _____ No _____

Is a 5 working day turnaround feasible for receipt of funds if they do not accept Visa? Yes _____ No _____

Vendor's Federal ID# _____ or SS# _____

Phone _____ Date(s) of service _____ Amount of Request \$ _____

Justification: _____

Other Enablers - (e.g., Juice, Applesauce, Bottled Water, etc.) - Approval: _____

Patient's Name _____ SS# _____

Name of Vendor _____ Vendor's Federal ID# _____

Will vendor accept state VISA card for payment? Yes _____ No _____

Payment Mailing Address _____ City/State _____ Zip _____

Phone _____ Amount of Request \$ _____

Sustacal/Boost Order **Approval Signature:** _____

CHD _____ Ship To Address _____

Requestor _____ TB Nurse (Contact Person) _____

Vanilla _____ # of cases _____ Vanilla Pudding _____ # of cases _____

Chocolate _____ # of cases _____ Chocolate Pudding _____ # of cases _____

Strawberry _____ # of cases _____ ButterScotch Pudding _____ # of cases _____

Choice DM Vanilla/Chocolate _____ # of cases _____

FOOD Coupons (Winn Dixie, Publix & McDonald's)
{Please Follow Previously Established Procedures}