Department of Public Health and Social Services
Division of Public Welfare ⬧ Work Programs Section
123 Chalan Kareta Mangilao, Guam 96913-6304
Telephone 735-7256 ⬧ Fax 734-5955

PARTICIPANT REIMBURSEMENT REQUEST (PRR)

Direct Payment#
_____

Control #:_____

Social Worker:
_____

Program: JOBS or GETP

Participant Name:	Mailing Address:
Social Security Number:	
	Contact Numbers:
Case Number:	Vendor Number:

I am requesting reimbursement of the following expenses incurred from _____to_____:

[ ] Transportation $_____   [ ] Ancillary $_____   [ ] Teen Parent Allowance $_____

(Original Detailed Receipts **MUST** be Attached)

I hereby certify that expenses for which I am seeking reimbursement have been paid by me. I understand that it is a federal crime punishable by fine and/or imprisonment, to knowingly make any false statement(s).

_____   _____
                    PARTICIPANT SIGNATURE   **DATE**

The Department of Public Health and Social Services (DPHSS) shall pay expenses incurred for supportive services for families eligible to receive such assistance. Payment shall only be made when this Reimbursement Request Form is completed and accompanied by other documentation required by the Program. **Documents must be submitted to DPHSS, Division of Public Welfare – Work Programs Section, by the 5th work day of each month but no later than 30 calendar days after the last day of the month in which reimbursement is requested.**

Example: October 2014 PRR is due by the 5th work day in November 2014 but no later than November 30, 2014 (30 calendar days).

FOR OFFICIAL USE ONLY (DO NOT WRITE BELOW THIS LINE)

Date Authorized:_____	**[ ] GETP [ ] JOBS**
Approved: Transportation: $_____	ATTACHMENTS:
Ancillary: $_____	[ ] CHILD CARE CALENDAR [ ] CHECK STUBS
Teen Parent: $_____	[ ] RECEIPT(S) [ ] ATTENDANCE CALENDAR
Service Month:_____	[ ]TRANSPORTATION REPORT [ ] OTHER _____
WPS Staff:	**WPS Case File #:_____**
Date Processed:	WPS Staff:

MISC COMMENTS/NOTES (Official Use Only):