REQUEST FOR EXPENDITURE

Select **one** of the following**:**

DMH funds

Consumer Funds at RO: One time  Recurring

Consumer Funds at Provider  *See note below*

DATE:

INDIVIDUAL’S NAME:       DMH #:       PROVIDER:

ITEM(S) REQUESTED:

AMOUNT REQUESTED: $       CURRENT PRS BALANCE $

JUSTIFICATION FOR REQUEST:

CHECK MADE PAYABLE TO:

CHECK GOES TO:

Reimbursement  Payment Up Front

Support Coordinator Signature/Date Supervisor Signature/Date

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REGIONAL OFFICE  AUTHORIZES  DENIES THE ABOVE EXPENDITURE

(*Indicate Reason Below)*:

Regional Director/Designee Signature/Date

Check #

Check Date

B.O. Initials

NOTE: Per Division Directive 5.070 purchases totaling $300 or more per day from funds held at the home shall not be made without the written permission/approval of the authorizing Representative Payee or designee.

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**THIS FORM IS VALID FOR (60) sixty days from date of authorized signature. For payment upfront receipts must be submitted within 30 days of consumer banking check date.**

Revised 7/1/22