

# 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 AND REASONING:

\_\_\_\_\_  
Regional Director/Designee Signature/Date

\_\_\_\_\_  
\_\_\_\_\_

Check # \_\_\_\_\_ Check Date \_\_\_\_\_ B.O. Initials \_\_\_\_\_

NOTE: Per Division Directive 5.070 purchases totaling \$100 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.**