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

****

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.

Revised 6/22/18