

Cumberland County Mental Health Auxiliary Payee Account Request Form

Please Print Payee Request Information:

Consumer Name: _____

Case Manager: _____ **Telephone Number:** _____

Provider Name: _____

Please indicate whether you would like bill request to be mailed. If you would like your request to be mailed please remember to include correct address. Also remember to indicate to whom completed checks should be delivered to if there are special delivery instructions.

Please Print Payment Information:

OFFICE USE ONLY		PAYABLE TO / ADDRESS:	LODGING AMOUNT	UTILITIES AMOUNT	FOOD AMOUNT	PERSONAL AMOUNT	MAIL	PICK-UP	PURPOSE OF REQUEST
	1.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
	2.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
	3.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
	4.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
	5.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
	6.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
	7.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
	8.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
	9.		\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	

I understand that for all check(s), RECEIPTS ARE REQUIRED. Receipts must be turned in within 24 hours after check(s) are issued.

SIGNATURE _____ DATE _____