COMMUNITY MENTAL HEALTH OF ST. JOSEPH COUNTY

STIPEND VOUCHER

DATE SUBMITTED _____/_____/_____ DAYTIME TELEPHONE NO: _____

NAME: _____

ADDRESS: _____
Street Address City State Zip Code

SERVICE ACTIVITY: _____

MILEAGE: _____

*Any payments that total $600.00 or more in any one calendar year will be reported to the IRS as required by regulations.
*You are responsible for reporting any income from the Voucher to the Social Security Administration and/or the Internal Revenue Service. Payments could impact your eligibility for benefits.
*CMHSJC cannot pay you if you wait more than 90 days to turn in a Voucher. CMHSJC will pay you within 30 days of receipt of the Voucher

SIGNATURES:

Consumer or Family Member: _____

CMHSJC Representative: _____

ACCOUNTS PAYABLE DEPARTMENT

Stipend $_____

Mileage $_____

Amount of Voucher $_____