the Advocacy Alliance
A Mental Health Association
846 Jefferson Avenue P.O. Box 1368 Scranton, PA 18501
(T) 570-342-7762 • (TF) 1-877-315-6855 • (F) 570-969-6922 • (E) info@theadvocacyalliance.org • (W) www.theadvocacyalliance.org

REPRESENTATIVE PAYEE PROGRAM
Consumer Check Request Form

Date: _____

Consumer Name: _____

Accounts Specialist Name: _____

Amount Requested: $ _____

Purpose of Request: _____

Requested By: _____

Supervisor Signature: _____

Check is to be made payable to: _____

Check is to be sent to the following address:

_____
_____
_____
_____

The Advocacy Alliance use only:
Check sent out by: _____ **on** _____
Amount of check $ _____
Receipts received on: _____
Amount of excess funds, if any $ _____ **and received on** _____