



Consumer and Family Member Stipend Invoice

DATE: _____

TO:

Addictions and Mental Health Division
Attn: Mental Health Planner
500 Summer Street NE E-86
Salem OR 97301-1118

PCA Code:
Index:

FROM:

(Name)
(Mailing Address)
(City, State, Zip)
(Phone Number)
(Email Address)
(Social Security #)

SERVICES PROVIDED:

Consumer/Family Member Participation on (check one):

- AMHPAC - Date of Meeting: _____
- CSAC – Date of Meeting: _____
- AMHPAC Subcommittee – Name of Subcommittee: _____
Date of Meeting: _____
- CSAC Subcommittee – Name of Subcommittee: _____
Date of Meeting: _____

TOTAL AMOUNT: \$50.00

I agree that I have not and will not receive compensation for my participation in the above AMH Advisory Council from any other source.

Member Signature Date: