



**Consumer and Family Member Stipend Invoice**

**DATE:** \_\_\_\_\_

**TO:**

Health Systems Division  
Attn: Roberto Coto  
500 Summer Street NE E-86  
Salem, OR 97301-1118

Index 84000; PCA 80282; ABOJ \_\_\_\_\_

**FROM:**

<b>(Name)</b>	
<b>(Mailing Address)</b>	
<b>(City, State, Zip)</b>	
<b>(Email Address)</b>	
<b>(Phone Number)</b>	
<b>(Social Security #)</b>	

**SERVICES PROVIDED:**

Consumer/Family Member Participation on (check one):

- CSAC – Date of Meeting: \_\_\_\_\_ \$ 50.00
- CSAC Subcommittee \_\_\_\_\_ \$ 50.00  
Name of Subcommittee: \_\_\_\_\_
- Date of Subcommittee: \_\_\_\_\_

**TOTAL AMOUNT:** \$ \_\_\_\_\_

**I agree that I have not and will not receive compensation for my participation in the above Children’s System Advisory Committee from any other source.**

\_\_\_\_\_  
**Member Signature**

\_\_\_\_\_  
**Date**