Consumer and Family Member Stipend Invoice

DATE: _____

TO: Health Systems
Division Attn: Nat
Jacobs & Jula Krewson

500 Summer Street NE
E-86 Salem, OR
97301-1118

Index 84000; PCA 80302; ABOJ ____

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

SERVICES PROVIDED: ($50.00 per meeting)
Consumer/Family Member Participation on (check one):

☐ CSAC – Date of Meeting: _____ _____

☐ CSAC Subcommittee
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**