Member Stipend Invoice

DATE: _____

TO:

Health Systems Division
500 Summer Street NE, E86
Salem, OR 97301-1118

Contact: Hilary.Harrison@state.or.us

FROM:

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

SERVICES PROVIDED:
Youth/Family Member Participation on:

☐ Name and date of meeting System of Care Advisory Council $ 30.00

☐ Name and date of meeting _____ $_____

TOTAL AMOUNT: $ _____

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

_____ _____

Member Signature **Date**