

TRANSMITTAL TO ALAMEDA COUNTY SUBSTITUTE PAYEE PROGRAM

FAX (510) 383-1583 PO Box 129 San Leandro, CA 94577 Phone (510) 383-1582

PART II – Disbursement/Payment Request

PST: ☒ Gina Miller ☐ Hilda Garcia ☐ Laurie Pauselius ☐ Linda Walters ☐ Maria Gonzalez-Ruiz ☐ Rosa Rivera

Client Name: Smith Client U D.O.B. 03/03/73 Client Number: 033333333  
LAST FIRST M.I.

Client's Current Address: 1234 Someplace Lane Any City, CA 12345  
STREET ADDRESS CITY /STATE/ZIP CODE

Effective Date of Client Address: 12/14/09

**SAMPLE #1 – ONE TIME ONLY**

Type of Request: ☒ One Time Only Disbursement ☐ Revise Budget/Same Address  
☐ Create Initial Budget (Submit Part I & II) ☐ New Budget/New Address (Submit Part I & II)

**DISBURSEMENT INFORMATION:**

**1. NAME OF VENDOR/PAYEE OR FACILITY:**

Client Smith

**2. ADDRESS:** 1234 Someplace Lane

**City:** Any City **State:** CA **Zip Code:** 12345

**3. ANTICIPATED DATE OF CHECK:** 04/10/10

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_

**5. FREQUENCY:**

- ▶ ☒ ONE TIME ONLY  
▶ ☐ WEEKLY ON: ☐ TUES ☐ THURS  
▶ ☐ MONTHLY ON THE: ☐ 1<sup>ST</sup> ☐ 3<sup>RD</sup> ☐ 15<sup>TH</sup>  
▶ ☐ SEMI-MONTHLY One check issued on the 1<sup>st</sup> AND 15<sup>th</sup>  
for the same amount

**6. HOLD FOR PICKUP?** ☐ YES ☒ NO

**7. WHY (Payment is for):** Spending Money

**8. AMOUNT OF CHECK:** \$ 100

☐ Prorate 1<sup>st</sup> Month's Payment

**9. PAYMENT IS FOR ACCOUNT NO:** \_\_\_\_\_  
(THIS NUMBER WILL APPEAR ON THE CHECK)

**10. Notes/Explanations** (This will not appear on the check): \_\_\_\_\_

**DISBURSEMENT INFORMATION:**

**1. NAME OF VENDOR/PAYEE OR FACILITY:**

**2. ADDRESS:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**3. ANTICIPATED DATE OF CHECK:** \_\_\_\_\_

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_

**5. FREQUENCY:**

- ▶ ☐ ONE TIME ONLY  
▶ ☐ WEEKLY ON: ☐ TUES ☐ THURS  
▶ ☐ MONTHLY ON THE: ☐ 1<sup>ST</sup> ☐ 3<sup>RD</sup> ☐ 15<sup>TH</sup>  
▶ ☐ SEMI-MONTHLY One check issued on the 1<sup>st</sup> AND 15<sup>th</sup>  
for the same amount

**6. HOLD FOR PICKUP?** ☐ YES ☐ NO

**7. WHY (Payment is for):** \_\_\_\_\_

**8. AMOUNT OF CHECK:** \$

**9. PAYMENT IS FOR ACCOUNT NO:** \_\_\_\_\_  
(THIS NUMBER WILL APPEAR ON THE CHECK)

**11. SUBMITTED BY (PRINT):** Case Manager's Name Printed **SITE:** SPP

**PHONE NUMBER:** 510-383-1557

**12. AUTHORIZING SIGNATURE:** Case Manager Signature **TITLE:** Case Manager

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**Fax Budget Requests to (510) 383-1583. Requests received after 9:30 a.m. on a check run day will be processed on the next check run date.**

**TRANSMITTAL TO ALAMEDA COUNTY SUBSTITUTE PAYEE PROGRAM**

FAX (510) 383-1583 PO Box 129 San Leandro, CA 94577 Phone (510) 383-1582

**PART I - Budget/Change Address Request**PST: ☒ Gina Miller ☐ Hilda Garcia ☐ Laurie Pauselius ☐ Linda Walters ☐ Maria Gonzalez-Ruiz ☐ Rosa Rivera**COMPLETE PARTS I AND II FOR ADDRESS/LIVING ARRANGEMENT CHANGES. SUBMIT PART II ONLY FOR ONE TIME ONLY PAYMENTS AND/OR CHANGES TO THE CURRENT BUDGET.****SAMPLE #2 : P1 - CHANGE OF ADDRESS RM/BD FACILITY**Client Name: Smith Client U D.O.B. 03/03/73 Client Number: 033333333  
LAST FIRST M.I.Type of Request: ☐ Create Initial Budget (Complete sections 1 - 8 below AND Part II)  
☒ New Budget/New Address (Complete 1 - 9 AND Part II)☐ Stop All Payments (Reason): \_\_\_\_\_Notification of: ☐ Whereabouts Unknown (Last Contact Date): \_\_\_\_\_  
☐ Incarceration (Complete 1, 2, 3, 4, 5 and 9) Date Incarcerated: \_\_\_\_\_ Date Released: \_\_\_\_\_  
☐ Hospitalization (Complete 1, 2, 3, 4, 5 and 9) Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_**Client's New Physical Address:**1. Name of Facility: Renee's Board and Care  
2. Address: 1234 Someplace Lane  
City: Any City State: CA Zip Code: 12345**Client's Mailing Address:**City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_Phone: (510) 555-3000 Eff. Date: 04/10/103. Living Arrangement Type: ☒ AA Independent Living ☐ AC Independent Living/Without Cooking Facilities  
☐ DJ Hospitalized or Long-Term-Care ☐ AB Licensed Board and Care ☐ BD Household of Another  
☐ N2 Incarcerated ☐ NO State Hospital**4. Address Type:**☐ AWOL/Whereabouts Unknown ☐ Homeless Shelter ☐ Homeless/On the Streets ☐ Household of Another ☐ IMD  
☐ Independent Living ☐ Licensed B&C ☐ Medical Facility ☐ Mental Health Rehab ☒ Room & Board  
☐ Skilled Nursing ☐ Transitional Housing ☐ Transient ☐ Villa ☐ JGP ☐ Alcohol/Drug Rehab ☐ Santa Rita  
☐ Other jail/prison ☐ Other (Explain): \_\_\_\_\_ (use additional sheet if necessary)**Note: If client is in a licensed board & care home, room & board, incarcerated, or hospitalized STOP (5-7 not applicable).****5. Housing Type:**☐ Apartment ☐ Homeless ☐ House ☐ Hotel ☐ Motel ☐ Shelter ☐ Transient ☐ Other: \_\_\_\_\_**6. Living Arrangements:**Lives alone? ☐ Yes ☐ No Has access to working stove, hot plate or microwave? ☐ Yes ☐ No  
Pays for utilities? ☐ Yes ☐ No Has access to working refrigerator? ☐ Yes ☐ No  
Shares household expenses? ☐ Yes ☐ No Is food available or at least one meal provided per day? ☐ Yes ☐ No  
Rents room only? ☐ Yes ☐ No Subsidized housing (check one): ☐ HUD ☐ Other ☐ None7. Landlord/Owner Name: \_\_\_\_\_ Landlord/Owner at same address? ☐ Yes ☐ No

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) - Relationship to client: \_\_\_\_\_**REMINDER: Send a copy of the Rental Statement or Agreement to the PST within 10 working days.**8. Submitted by: Case Manager's Name Printed Site: SPP Date Submitted: 04/10/10  
PRINT9. SIGNATURE: Case Manager Signature PHONE: (510) 383-1557

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## TRANSMITTAL TO ALAMEDA COUNTY SUBSTITUTE PAYEE PROGRAM

FAX (510) 383-1583 PO Box 129 San Leandro, CA 94577 Phone (510) 383-1582

## PART II – Disbursement/Payment Request

PST: ☒ Gina Miller ☐ Hilda Garcia ☐ Laurie Pauselius ☐ Linda Walters ☐ Maria Gonzalez-Ruiz ☐ Rosa RiveraClient Name: Smith Client U D.O.B. 03/03/73 Client Number: 033333333  
LAST FIRST M.I.Client's Current Address: 1234 Someplace Lane Any City, CA 12345  
STREET ADDRESS CITY /STATE/ZIP CODEEffective Date of Client Address: 04/10/10**SAMPLE #2 : P2**Type of Request: ☐ One Time Only Disbursement ☐ Revise Budget/Same Address  
☐ Create Initial Budget (Submit Part I & II) ☒ New Budget/New Address (Submit Part I & II)**DISBURSEMENT INFORMATION:****1. NAME OF VENDOR/PAYEE OR FACILITY:**Renee's Board and Care**2. ADDRESS:** 1234 Anywhere StreetCity: Any City State: CA Zip Code: 12345**3. ANTICIPATED DATE OF CHECK:** 04/13/10

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_**5. FREQUENCY:**

- ☐ ONE TIME ONLY
- ☐ WEEKLY ON: ☐ TUES ☐ THURS
- ☒ MONTHLY ON THE: ☐ 1<sup>ST</sup> ☒ 3<sup>RD</sup> ☐ 15<sup>TH</sup>
- ☐ SEMI-MONTHLY One check issued on the 1<sup>st</sup> AND 15<sup>th</sup> for the same amount

**6. HOLD FOR PICKUP?** ☐ YES ☒ NO**7. WHY (Payment is for):** Room and Board**8. AMOUNT OF CHECK:** \$ 600☐ Prorate 1<sup>st</sup> Month's Payment**9. PAYMENT IS FOR ACCOUNT NO:** \_\_\_\_\_  
(THIS NUMBER WILL APPEAR ON THE CHECK)**10. Notes/Explanations** (This will not appear on the check): \_\_\_\_\_**11. SUBMITTED BY (PRINT):** Case Manager's Name Printed **SITE:** SPP**PHONE NUMBER:** 510-383-1557**12. AUTHORIZING SIGNATURE:** Case Manager Signature **TITLE:** Case Manager

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## TRANSMITTAL TO ALAMEDA COUNTY SUBSTITUTE PAYEE PROGRAM

FAX (510) 383-1583 PO Box 129 San Leandro, CA 94577 Phone (510) 383-1582

## PART II – Disbursement/Payment Request

PST: ☒ Gina Miller ☐ Hilda Garcia ☐ Laurie Pauselius ☐ Linda Walters ☐ Maria Gonzalez-Ruiz ☐ Rosa RiveraClient Name: Smith Client U D.O.B. 03/03/73 Client Number: 033333333  
LAST FIRST M.I.Client's Current Address: 1234 Someplace Lane Any City, CA 12345  
STREET ADDRESS CITY /STATE/ZIP CODEEffective Date of Client Address: 04/10/10**SAMPLE #2 : P3**Type of Request: ☒ One Time Only Disbursement ☐ Revise Budget/Same Address  
☐ Create Initial Budget (Submit Part I & II) ☐ New Budget/New Address (Submit Part I & II)**DISBURSEMENT INFORMATION:****1. NAME OF VENDOR/PAYEE OR FACILITY:**

Renee's Board and Care

**2. ADDRESS:** 1234 Anywhere StreetCity: Any City State: CA Zip Code: 12345**3. ANTICIPATED DATE OF CHECK:** 04/13/10

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_**5. FREQUENCY:**

- ▶ ☒ ONE TIME ONLY
- ▶ ☐ WEEKLY ON: ☐ TUES ☐ THURS
- ▶ ☐ MONTHLY ON THE: ☐ 1<sup>ST</sup> ☐ 3<sup>RD</sup> ☐ 15<sup>TH</sup>
- ▶ ☐ SEMI-MONTHLY One check issued on the 1<sup>st</sup> AND 15<sup>th</sup> for the same amount

**6. HOLD FOR PICKUP?** ☐ YES ☒ NO**7. WHY (Payment is for):** Room and Board for April 2010**8. AMOUNT OF CHECK:** \$ 50☒ Prorate 1<sup>st</sup> Month's Payment**9. PAYMENT IS FOR ACCOUNT NO:** \_\_\_\_\_  
(THIS NUMBER WILL APPEAR ON THE CHECK)**10. Notes/Explanations** (This will not appear on the check): \_\_\_\_\_**11. SUBMITTED BY (PRINT):** Case Manager's Name Printed **SITE:** SPP**PHONE NUMBER:** 510-383-1557**12. AUTHORIZING SIGNATURE:** Case Manager Signature **TITLE:** Case Manager

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**TRANSMITTAL TO ALAMEDA COUNTY SUBSTITUTE PAYEE PROGRAM****FAX (510) 383-1583** PO Box 129 San Leandro, CA 94577 Phone (510) 383-1582**PART II – Disbursement/Payment Request**PST: ☒ Gina Miller ☐ Hilda Garcia ☐ Laurie Pauselius ☐ Linda Walters ☐ Maria Gonzalez-Ruiz ☐ Rosa RiveraClient Name: Smith Client U D.O.B. 03/03/73 Client Number: 033333333  
LAST FIRST M.I.Client's Current Address: 1234 Someplace Lane Any City, CA 12345  
STREET ADDRESS CITY /STATE/ZIP CODEEffective Date of Client Address: 12/14/09**SAMPLE #3 : ONE TIME ONLY X2**Type of Request: ☒ One Time Only Disbursement ☐ Revise Budget/Same Address  
☐ Create Initial Budget (Submit Part I & II) ☐ New Budget/New Address (Submit Part I & II)**DISBURSEMENT INFORMATION:****1. NAME OF VENDOR/PAYEE OR FACILITY:**Client Smith**2. ADDRESS:** P.O. Box 354City: Any City State: CA Zip Code: 12345**3. ANTICIPATED DATE OF CHECK:** 04/15/10

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_**5. FREQUENCY:**

- ▶ ☒ **ONE TIME ONLY**
- ▶ ☐ **WEEKLY ON:** ☐ TUES ☐ THURS
- ▶ ☐ **MONTHLY ON THE:** ☐ 1<sup>ST</sup> ☐ 3<sup>RD</sup> ☐ 15<sup>TH</sup>
- ▶ ☐ **SEMI-MONTHLY** One check issued on the 1<sup>st</sup> AND 15<sup>th</sup> for the same amount

**6. HOLD FOR PICKUP?** ☐ YES ☒ NO**7. WHY (Payment is for):** Bus Pass**8. AMOUNT OF CHECK:** \$ 27☐ Prorate 1<sup>st</sup> Month's Payment**9. PAYMENT IS FOR ACCOUNT NO:** \_\_\_\_\_  
(THIS NUMBER WILL APPEAR ON THE CHECK)**10. Notes/Explanations** (This will not appear on the check): \_\_\_\_\_**11. SUBMITTED BY (PRINT):** Case Manager's Name Printed **SITE:** SPP**PHONE NUMBER:** 510-383-1557**12. AUTHORIZING SIGNATURE:** Case Manager Signature **TITLE:** Case Manager

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FAX (510) 383-1583 PO Box 129 San Leandro, CA 94577 Phone (510) 383-1582

**PART I - Budget/Change Address Request**PST: ☒ Gina Miller ☐ Hilda Garcia ☐ Laurie Pauselius ☐ Linda Walters ☐ Maria Gonzalez-Ruiz ☐ Rosa Rivera**COMPLETE PARTS I AND II FOR ADDRESS/LIVING ARRANGEMENT CHANGES. SUBMIT PART II ONLY FOR ONE TIME ONLY PAYMENTS AND/OR CHANGES TO THE CURRENT BUDGET.****SAMPLE #4 - HOSPITALIZED**Client Name: Smith Client U D.O.B. 03/03/73 Client Number: 033333333  
LAST FIRST M.I.Type of Request: ☐ Create Initial Budget (Complete sections 1 - 8 below AND Part II)  
☐ New Budget/New Address (Complete 1 - 9 AND Part II)☒ Stop All Payments (Reason): HospitalizedNotification of: ☐ Whereabouts Unknown (Last Contact Date): \_\_\_\_\_  
☐ Incarceration (Complete 1, 2, 3, 4, 5 and 9) Date Incarcerated: \_\_\_\_\_ Date Released: \_\_\_\_\_  
☒ Hospitalization (Complete 1, 2, 3, 4, 5 and 9) Admit Date: 04/10/10 Discharge Date: \_\_\_\_\_**Client's New Physical Address:**1. Name of Facility: Morning Star Hospital2. Address: 1111 Anywhere PlaceCity: Any City State: CA Zip Code: 12345**Client's Mailing Address:**City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_Phone: (510) 555-3000 Eff. Date: 04/10/103. Living Arrangement Type: ☐ AA Independent Living ☐ AC Independent Living/Without Cooking Facilities  
☒ DJ Hospitalized or Long-Term-Care ☐ AB Licensed Board and Care ☐ BD Household of Another  
☐ N2 Incarcerated ☐ NO State Hospital**4. Address Type:**☐ AWOL/Whereabouts Unknown ☐ Homeless Shelter ☐ Homeless/On the Streets ☐ Household of Another ☐ IMD  
☐ Independent Living ☐ Licensed B&C ☒ Medical Facility ☐ Mental Health Rehab ☐ Room & Board  
☐ Skilled Nursing ☐ Transitional Housing ☐ Transient ☐ Villa ☐ JGP ☐ Alcohol/Drug Rehab ☐ Santa Rita  
☐ Other jail/prison ☐ Other (Explain): \_\_\_\_\_ (use additional sheet if necessary)**Note: If client is in a licensed board & care home, room & board, incarcerated, or hospitalized STOP (5-7 not applicable).****5. Housing Type:**☐ Apartment ☐ Homeless ☐ House ☐ Hotel ☐ Motel ☐ Shelter ☐ Transient ☐ Other: \_\_\_\_\_**6. Living Arrangements:**Lives alone? ☐ Yes ☐ No Has access to working stove, hot plate or microwave? ☐ Yes ☐ No  
Pays for utilities? ☐ Yes ☐ No Has access to working refrigerator? ☐ Yes ☐ No  
Shares household expenses? ☐ Yes ☐ No Is food available or at least one meal provided per day? ☐ Yes ☐ No  
Rents room only? ☐ Yes ☐ No Subsidized housing (check one): ☐ HUD ☐ Other ☐ None7. Landlord/Owner Name: \_\_\_\_\_ Landlord/Owner at same address? ☐ Yes ☐ No

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) - Relationship to client: \_\_\_\_\_**REMINDER: Send a copy of the Rental Statement or Agreement to the PST within 10 working days.**8. Submitted by: Case Manager's Name Printed Site: SPP Date Submitted: 04/10/10  
PRINT9. SIGNATURE: Case Manager Signature PHONE: (510) 383-1557

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FAX (510) 383-1583 PO Box 129 San Leandro, CA 94577 Phone (510) 383-1582

**PART I - Budget/Change Address Request**PST: ☒ Gina Miller ☐ Hilda Garcia ☐ Laurie Pauselius ☐ Linda Walters ☐ Maria Gonzalez-Ruiz ☐ Rosa Rivera**COMPLETE PARTS I AND II FOR ADDRESS/LIVING ARRANGEMENT CHANGES. SUBMIT PART II ONLY FOR ONE TIME ONLY PAYMENTS AND/OR CHANGES TO THE CURRENT BUDGET.****SAMPLE #5 : PG 1 – CHANGE OF ADDRESS & NEW BUDGET**Client Name: Smith Client U D.O.B. 03/03/73 Client Number: 033333333  
LAST FIRST M.I.Type of Request: ☐ Create Initial Budget (Complete sections 1 - 8 below AND Part II)  
☒ New Budget/New Address (Complete 1 – 9 AND Part II)☐ Stop All Payments (Reason): \_\_\_\_\_Notification of: ☐ Whereabouts Unknown (Last Contact Date): \_\_\_\_\_  
☐ Incarceration (Complete 1, 2, 3, 4, 5 and 9) Date Incarcerated: \_\_\_\_\_ Date Released: \_\_\_\_\_  
☐ Hospitalization (Complete 1, 2, 3, 4, 5 and 9) Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_**Client's New Physical Address:**

1. Name of Facility: \_\_\_\_\_

2. Address: 1111 Anywhere PlaceCity: Any City State: CA Zip Code: 12345Phone: (510) 555-3000Eff. Date:  **Client's Mailing Address:**City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_3. Living Arrangement Type: ☒ AA Independent Living ☐ AC Independent Living/Without Cooking Facilities  
☐ DJ Hospitalized or Long-Term-Care ☐ AB Licensed Board and Care ☐ BD Household of Another  
☐ N2 Incarcerated ☐ NO State Hospital**4. Address Type:**☐ AWOL/Whereabouts Unknown ☐ Homeless Shelter ☐ Homeless/On the Streets ☐ Household of Another ☐ IMD  
☒ Independent Living ☐ Licensed B&C ☐ Medical Facility ☐ Mental Health Rehab ☐ Room & Board  
☐ Skilled Nursing ☐ Transitional Housing ☐ Transient ☐ Villa ☐ JGP ☐ Alcohol/Drug Rehab ☐ Santa Rita  
☐ Other jail/prison ☐ Other (Explain): \_\_\_\_\_ (use additional sheet if necessary)**Note: If client is in a licensed board & care home, room & board, incarcerated, or hospitalized STOP (5-7 not applicable).****5. Housing Type:**☒ Apartment ☐ Homeless ☐ House ☐ Hotel ☐ Motel ☐ Shelter ☐ Transient ☐ Other: \_\_\_\_\_**6. Living Arrangements:**Lives alone? ☐ Yes ☒ No Has access to working stove, hot plate or microwave? ☒ Yes ☐ No  
Pays for utilities? ☐ Yes ☒ No Has access to working refrigerator? ☒ Yes ☐ No  
Shares household expenses? ☒ Yes ☐ No Is food available or at least one meal provided per day? ☐ Yes ☒ No  
Rents room only? ☒ Yes ☐ No Subsidized housing (check one): ☒ HUD ☐ Other ☐ None7. Landlord/Owner Name: Mr. Landlord Landlord/Owner at same address? ☐ Yes ☒ NoAddress: 333 Rent Street City: Another City State: CA Zip Code: 12345Phone: (510) 555-5555 Relationship to client: Landlord**REMINDER: Send a copy of the Rental Statement or Agreement to the PST within 10 working days.**8. Submitted by: Case Manager's Name Printed Site: SPP Date Submitted: 04/10/10  
PRINT9. SIGNATURE: Case Manager Signature PHONE: (510) 383-1557

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LAST FIRST M.I.Client's Current Address: 1111 Anywhere Place Any City, CA 12345  
STREET ADDRESS CITY /STATE/ZIP CODEEffective Date of Client Address: 04/10/10**SAMPLE #5 : PG 2**Type of Request: ☐ One Time Only Disbursement ☐ Revise Budget/Same Address  
☐ Create Initial Budget (Submit Part I & II) ☒ New Budget/New Address (Submit Part I & II)**DISBURSEMENT INFORMATION:****1. NAME OF VENDOR/PAYEE OR FACILITY:**Mr. Landlord**2. ADDRESS:** 333 Rent StreetCity: Any City State: CA Zip Code: 12345**3. ANTICIPATED DATE OF CHECK:** 05/03/10

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_**5. FREQUENCY:**

- ▶ ☐ ONE TIME ONLY
- ▶ ☐ WEEKLY ON: ☐ TUES ☐ THURS
- ▶ ☒ MONTHLY ON THE: ☐ 1<sup>ST</sup> ☒ 3<sup>RD</sup> ☐ 15<sup>TH</sup>
- ▶ ☐ SEMI-MONTHLY One check issued on the 1<sup>st</sup> AND 15<sup>th</sup> for the same amount

**6. HOLD FOR PICKUP?** ☐ YES ☒ NO**7. WHY (Payment is for):** Rent**8. AMOUNT OF CHECK:** \$ 300☒ Prorate 1<sup>st</sup> Month's Payment**9. PAYMENT IS FOR ACCOUNT NO:** \_\_\_\_\_  
(THIS NUMBER WILL APPEAR ON THE CHECK)**10. Notes/Explanations** (This will not appear on the check): \_\_\_\_\_**DISBURSEMENT INFORMATION:****1. NAME OF VENDOR/PAYEE OR FACILITY:**Client Smith**2. ADDRESS:** P.O. Box 1234City: Any City State: CA Zip Code: 12345**3. ANTICIPATED DATE OF CHECK:** 04/15/10

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_**5. FREQUENCY:**

- ▶ ☐ ONE TIME ONLY
- ▶ ☐ WEEKLY ON: ☐ TUES ☐ THURS
- ▶ ☐ MONTHLY ON THE: ☐ 1<sup>ST</sup> ☐ 3<sup>RD</sup> ☐ 15<sup>TH</sup>
- ▶ ☒ SEMI-MONTHLY One check issued on the 1<sup>st</sup> AND 15<sup>th</sup> for the same amount

**6. HOLD FOR PICKUP?** ☐ YES ☒ NO**7. WHY (Payment is for):** Personal Needs**8. AMOUNT OF CHECK:** \$ 100**9. PAYMENT IS FOR ACCOUNT NO:** \_\_\_\_\_  
(THIS NUMBER WILL APPEAR ON THE CHECK)**11. SUBMITTED BY (PRINT):** Case Manager's Name Printed **SITE:** SPP**PHONE NUMBER:** 510-383-1557**12. AUTHORIZING SIGNATURE:** Case Manager Signature **TITLE:** Case Manager

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**TRANSMITTAL TO ALAMEDA COUNTY SUBSTITUTE PAYEE PROGRAM****FAX (510) 383-1583** PO Box 129 San Leandro, CA 94577 Phone (510) 383-1582**PART II – Disbursement/Payment Request**PST: ☒ Gina Miller ☐ Hilda Garcia ☐ Laurie Pauselius ☐ Linda Walters ☐ Maria Gonzalez-Ruiz ☐ Rosa RiveraClient Name: Smith Client U D.O.B. 03/03/73 Client Number: 033333333  
LAST FIRST M.I.Client's Current Address: 1111 Anywhere Place Any City, CA 12345  
STREET ADDRESS CITY /STATE/ZIP CODEEffective Date of Client Address: 04/10/10**SAMPLE #5 : PG 3**Type of Request: ☒ One Time Only Disbursement ☐ Revise Budget/Same Address  
☐ Create Initial Budget (Submit Part I & II) ☐ New Budget/New Address (Submit Part I & II)**DISBURSEMENT INFORMATION:****1. NAME OF VENDOR/PAYEE OR FACILITY:**Client Smith**2. ADDRESS:** 1111 Anywhere PlaceCity: Any City State: CA Zip Code: 12345**3. ANTICIPATED DATE OF CHECK:** 04/15/10

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_**5. FREQUENCY:**

- ▶ ☒ ONE TIME ONLY
- ▶ ☐ WEEKLY ON: ☐ TUES ☐ THURS
- ▶ ☐ MONTHLY ON THE: ☐ 1<sup>ST</sup> ☐ 3<sup>RD</sup> ☐ 15<sup>TH</sup>
- ▶ ☐ SEMI-MONTHLY One check issued on the 1<sup>st</sup> AND 15<sup>th</sup> for the same amount

**6. HOLD FOR PICKUP?** ☒ YES ☐ NO**7. WHY (Payment is for):** Food**8. AMOUNT OF CHECK:** \$ 30☐ Prorate 1<sup>st</sup> Month's Payment**9. PAYMENT IS FOR ACCOUNT NO:** \_\_\_\_\_  
(THIS NUMBER WILL APPEAR ON THE CHECK)**10. Notes/Explanations** (This will not appear on the check): \_\_\_\_\_**DISBURSEMENT INFORMATION:****1. NAME OF VENDOR/PAYEE OR FACILITY:**PG&E**2. ADDRESS:** P.O. Box 654City: Electric City State: CA Zip Code: 12345**3. ANTICIPATED DATE OF CHECK:** 05/01/10

(must be a check run date)

**4. END DATE** (if applicable): \_\_\_\_\_**5. FREQUENCY:**

- ▶ ☐ ONE TIME ONLY
- ▶ ☐ WEEKLY ON: ☐ TUES ☐ THURS
- ▶ ☒ MONTHLY ON THE: ☐ 1<sup>ST</sup> ☐ 3<sup>RD</sup> ☐ 15<sup>TH</sup>
- ▶ ☐ SEMI-MONTHLY One check issued on the 1<sup>st</sup> AND 15<sup>th</sup> for the same amount

**6. HOLD FOR PICKUP?** ☒ YES ☐ NO**7. WHY (Payment is for):** PG&E/ Utilities**8. AMOUNT OF CHECK:** \$ 60**9. PAYMENT IS FOR ACCOUNT NO:** 01-234567-8  
(THIS NUMBER WILL APPEAR ON THE CHECK)**11. SUBMITTED BY (PRINT):** Case Manager's Name Printed **SITE:** SPP**PHONE NUMBER:** 510-383-1557**12. AUTHORIZING SIGNATURE:** Case Manager Signature **TITLE:** Case Manager

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