**Representative Payee Additional Disbursement Request Form**

Please fax this form to BFC RPP Staff at 202-265-1970 or scan and email to a RPP Coordinator

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date of Request: |  | | | Provider Agency: | |  |
|  |  | | |  | |  |
| Consumer Name: | |  | | | SSN: | xxx-xx- |
|  | |  | | |  | |
| Clinical Team Member: | | |  | | Phone: |  |

**Checks are available after 10am on the 2nd business day after the request is received by RPP staff if pick-up at the NW Center is requested below. Incompletely filled out forms can cause delays in processing.**

**Request Information:** (please print CLEARLY or type)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | |
| **Pay check to:** |  | | | | | | | | | |
|  | | | | | | | | | | |
| Vendor Address: | |  | | | | | | | | |
|  | | | | | | | | | | |
| **Amount of Payment:** | | | |  | | | | |  | |
|  | | | | | | | | | | |
| Describe Expense: | | |  | | | | | | | |
|  | | | | | | | | | | |
| Details for Check Memo: | | | | | |  | | | | |
|  | | | | | | | | | | |
| **Disbursement Method:** | | | | | 🞎 Direct Deposit (**account already on file at BFC RPP only**) | | | | | |
|  | | | | | 🞎 mail to Vendor Address above | | | | | |
|  | | | | | 🞎 mail to: | |  | | | |
|  | | | | | | |  | | | |
|  | | | | | 🞏 include in next Agency Batch: | | | | |  |
|  | | | | | 🞎 pick-up NW by whom: | | |  | | |
|  | | | | | | | | | | |

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| --- |
| **Comments:** Requests this month: 🞏 1st 🞏 2nd |
|  |
|  |
| **For emergency processing describe the situation above in comments AND**  **contact RPP staff by email to confirm a pick-up date and time.** |

All Additional Disbursement Request Forms must include signatures of **both** the **Community Support Worker** and **Immediate Supervisor**. Request made payable in the name of a CSA staff member in any amount or payable to the consumer or to a third party in the amount of $250 or more must also include the signature of a **Senior Administrator/Clinical Director** or designee. **Requests of $250 or more and payable to the consumer must be picked up by or mailed to the Community Support Worker and require that receipts be returned to Bread for the City using the Receipts Tracker form.**  For payments of utility bills and other invoices please submit the bill itself in lieu of an ADRF and payment will be sent directly to the vendor.

**Signatures:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Clinical Team Member** | |  | Print Name: |  |
|  | |  |  |  |
| **Clinical Team Supervisor** | |  | Print Name: |  |
|  | |  |  |  |
| **Senior Administrator** |  | | Print Name: |  |