**PAYABLE TO:**

NAME/DEPT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CAREGIVER #: \_\_\_\_\_\_\_\_\_\_\_\_\_

(IF MOSAIC DEPT PLEASE PROVIDE COST CTR & ACCOUNT FOR TRANSFER) (ONLY NEED IF PAYEE IS A CAREGIVER)

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_

REQUEST DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE NEEDED: \_\_\_\_\_\_\_\_\_\_ AMOUNT: \_\_\_\_\_\_\_\_\_\_

**DISPOSITION:**☐ Mail Check ☐ Return to Foundation ☐ Other: Return to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ☐ Touchstone, L. Taylor ☐ Hospice, C. Roumph ☐ Include Invoice

**PURPOSE:**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHARGE TO:**

|  |  |  |  |
| --- | --- | --- | --- |
| **COMPANY** | **COST CENTER** | **ACCOUNT** | **AMOUNT** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Please refer to Standard# LD4500 for expenditure authority limits and guidelines.***

Requested By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TL/Mgr ($5,000 or less): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SL/PL ($50,000 or less): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

O/A ($50,000 or above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***All Related Receipts/Documentation Must Accompany this Check Request***