Health Care for the Homeless
Check Request Form

Issue check to:

Name/Organization _____

Mailing address _____

_____

New Vendor? ☐ yes ☐ (if yes, please see staff portal for a W-9 form)

Invoice # _____ Invoice date _____ HCH purchase # _____

Description _____

_____

_____

Amount requested _____

Grant _____

If client related:

HCH# _____

Client Name _____

Project Funding _____

Instructions

☐ Mail check to above address

☐ Mail check w/ attached materials

☐ Other _____

☐ Return check to requestor

☐ Hold check for pickup

Check requested by _____ date: _____

Approved by _____ date: _____

EXPENSE CODING

Check amount _____

Year _____

Period _____

Invoice period	Fund	GL code	Grant code	Contract	Dept	Amount

Prepared by: _____ Date _____

Reviewed by: _____ Date _____