|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FSAlogo | | | **AUTHORIZATION FOR EXPENDITURE**  **(NON-EMPLOYEE)** | | | | NO. | | | |
| 1. NAME | | | | | | | 2. SOCIAL SECURITY NO. | | | |
| 3. ADDRESS CITY STATE ZIP CODE | | | | | | | | | | |
| 4. PURPOSE OF EXPENDITURE AUTHORIZATION (DESCRIBE PURPOSE, NATURE OF SERVICES, LOCATION, ETC.  **Stipend requested:**  **Food- \_\_Yes \_\_ No $50.00**  **Travel in your own vehicle \_\_Yes \_\_ No -$75.00**  **Travel Gray Hound Bus \_\_Yes \_\_ No -DBHR will purchase** | | | | | | | | | | |
| 5. PERIOD OF AUTHORIZATION | | | | 6. EXPENDITURE AUTHORIZATION (AUTHORIZING OFFICIAL – INITIAL EACH ITEM CHECKED) | | | | | | |
| BEGINNING DATE | | ENDING DATE | | Long term travel authorization should be renewed annually.  a. Travel   b. Per Diem  INITIALS OF AUTHORIZING OFFICIAL INITIALS OF AUTHORIZING OFFICIAL | | | | | | |
| **10/02/2016** | | **10/04/2016** | |
| **7. TRAVEL AUTHORIZATION**  ***(COMPLETE ONLY IF TRAVEL AND/OR PER DIEM IS CHECKED AND INITIALED IN BOX 6 ABOVE). LONG TERM TRAVEL SHOULD BE RENEWED ANNUALLY.*** | | | | | | | | | | |
| 7a. SINGLE TRIP ITINERARY *(Do not complete for long-term authorizations)* | | | | | | | | | | |
| DATE | | FROM | | | TO | MILEAGE RATE | | PER DIEM RATE | | AMOUNT |
|  | |  | | |  | **NA** | |  | |  |
|  | |  | | |  | **NA** | |  | |  |
|  | |  | | |  | **NA** | |  | |  |
|  | | | | | | | | **TOTAL** | | **$** |
| 7b. LONG TERM TRAVEL AUTHORIZATION *(Do not use for single trips or short-term situations)* | | | | | | | | | | |
| MILEAGE RATE | PER DIEM RATE | | EXPECTED FREQUENCY OF TRAVEL *(OR OTHER CRITERIA)* | | | | | | | TOTAL EXPENDITURE AUTHORIZATION |
| **NA** | **NA** | |  | | | | | | **TOTAL** | **$** |
| **8. Maximum Expenditure Authorization Shall Not Exceed TOTAL** | | | | | | | | | | **$** |
| It is mutually understood by the parties hereto that the person named in item No. 1 above is not an employee of the Department of Social and Health Services nor an agent of the Department in any manner whatsoever, nor will he/she hold him (her) out to be such, nor claim to be such by reason hereof, and will not claim, demand, or apply to or for any right or privilege applicable to an officer or employee of the Department. Provided, that nothing herein contained shall be interpreted to preclude such person's lawful entitlements to benefits which might accrue to that person, his (her) non-employee status notwithstanding.  The non-employee named above will not in any manner while performing hereunder discriminate on the basis of race, color, religion, creed, national origin, sex, age, marital status, disabled or Vietnam-era veteran status, or handicap without there having been previously established a bona-fide qualification for good and sufficient cause by the Department.  This authorization and any proceeds therefrom are not assignable.  No information of a confidential nature concerning any client or recipient of the Department will be disclosed by the non-employee except on written consent of the client or recipient, his attorney, or his responsible parent or guardian.  Claims for reimbursement under this authorization will be submitted on the proper form designated by the Department.  This authorization constitutes the entire agreement between the parties hereto and no oral changes or representations shall be binding upon the Department. | | | | | | | | | | |
| **9. SIGNATURES** | | | | | | | | | | |
| SIGNATURE OF NON-EMPLOYEE | | | | | | | | | | DATE |
| SIGNATURE OF DSHS OFFICIAL | | | | | NAME  **Ruth Leonard** | | | | | DATE |
| TITLE  **Behavioral Health TX Manager** | | | | | ORGANIZATION  **Division of Behavioral Health & Recovery** | | | | | |