Client Compensation Agreement

Health Care for the Homeless ("the Agency") recognizes that the organization benefits from client contributions. By sharing testimony, expertise, and time, clients help advance Agency goals in advocacy, development, delivery of services, and more. To acknowledge the value of client contributions, the Agency will provide a monetary stipend or honorarium for the following qualified activities. (Please refer to the Client Compensation Policy and Procedure for more details.)

IF stipend activity (please check one) ___ Participating in Performance Improvement (or other workgroup) ___ Leading/co-leading client support group ___ Captaining/co-captaining a lobby day group ___ Providing oral testimony in Annapolis ___ Presenting at National Health Care for the Homeless Conference ___ Relationship-building and decision-making activities ___ Other ___________________________________
IF honorarium activity (please check one) ___ Interviewing for written/video piece for the Agency ___ Writing a story or other content piece for Agency publication ___ Submitting written/oral testimony for legislative advocacy ___ Presenting as part of a clinic tour ___ Serving as a Team (Co)Captain at Lobby Day ___ Third-party referral (e.g., news site) to speak about HCH services or advocacy priorities ___ Speaking at a one-time event as an Agency representative that does not require pre-event preparation ___ Other ____

__ Check if travel reimbursement will be required. # of tokens (if return round-trip): ____________

__ Other travel reimbursement requested. Please explain what is needed: ____________________

Provide relevant details below:

Event	**Date(s)**	**Estimated Hours**	**Location**	**Type of Service**

Client Name: ____

Date of Birth: ____

Address: ____

Telephone: ________________________________ Email: __________________________________

I agree to participate in the agency activity as specified above. I understand that at any time before or during the activity, I can decide not to participate. I understand that no longer participating may end future payments for that activity. This will in no way prevent me from taking part in future activities. My participation will have no effect on my care at the agency.

If you feel that your care has been affected by ending your participation, please call the Agency complaint line, 443-703-1414, or go to www.hchmd.org/client-feedback.

_____________________ ___________________________ _________________
Signature (Client) Printed Name Date

_____________________ ___________________________ _________________
Signature (Staff) Printed Name Date

RECEIPT

1099 Form Reporting
I understand that the Agency is required to report and issue 1099 forms to taxpayers who receive $600 or more in non-employment income during the tax year. I understand that if I receive SSI/SSDI, my benefits could be affected if the total amount for the tax year reaches $600. If an individual reaches $600 total for the year, they will be notified by staff.

I am receiving a payment of $______ for ___ hours/days of my participation in the above qualifying agency activity. In addition, I am receiving __________________ for related transportation.

_____________________ ___________________________ _________________
Client Signature Printed Name Date

_____________________ ___________________________ _________________
Approved by Printed Name Date

Expense Coding

Invoice Period	Fund	GL Code	Grant Code	Dept	Amount
		5593		13	