PROTECTIVE PAYEE REPORT CONTINUATION

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Month _____, Year _____

7. NAME AND ADDRESS OF BANK	1. COMMUNITY SERVICES OFFICE (CSO)
	2. CASE WORKER/CASE MANAGER'S NAME
	3. WORKER'S TELEPHONE NUMBER
	4. RECIPIENT'S NAME
8. ACCOUNT NUMBER	5. RECIPIENT'S ASSISTANCE UNIT ID NUMBER 6. RECIPIENT'S INDIVIDUAL ID NUMBER

9. TRANSACTION RECORD

A. TRANSACTION DATE	B. CHECK NUMBER	C. AMOUNT	D. TYPE	E. PURPOSE (RECIPIENT MUST SIGN HERE IF CASH WAS DISBURSED)	F. DOC	G. BALANCE
			☐ DEPOSIT ☐ WITHDRAWAL			
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10. STATEMENT OF ACCURACY

I certify this is an accurate record of income, expenditures, and case actions.

PROTECTIVE PAYEE NAME (PRINT)	SIGNATURE	DATE

DISTRIBUTION: Original - CSO   Copy - Protective Payee

PAGE _____ OF _____

DSHS 01-110C (02/1999)

Protective Payee Report Continuation

A. Completing and using the form

Protective payee vendors use this form when there is not enough space on the Protective Payee Report, DSHS 01-110(X).

Complete the form, including the page information at the base of the form, and attach it to the Protective Payee Report, DSHS 01-110(X).

B. Distribution

Original: Community Services Office

Copy: Protective Payee file.