

Consumer Name _____ Date of Birth _____ CBI/CRF



AGREEMENT FOR REPAYMENT FORM

**To: Adult Mental Health Division (AMHD)
Utilization Management (UM)**

I, _____, will / will not be repaying the CBI CRF.
(Print client's name)

As discussed with my case manager, I have set-up a repayment plan starting _____
(date)
for increments of _____ dollars per month.

My case manager will notify AMHD UM in writing, if there are any changes in this agreement.
This repayment is part of my treatment plan. Thank you very much.

Client's signature	Date
Case Manager's signature	Date

**All repayments must be sent to: Egami & Ichikawa CPAs
615 Piikoi St Suite 2001
Honolulu, HI 96814**