

AGREEMENT TO REPAY SAM FUNDS

Consumer _____ Agency _____

Address _____ Case Manager _____

Medical Record # _____

I, _____ (consumer), agree to repay the loan of \$ _____ made to me by the Milwaukee County Behavioral Health Division SAIL Unit at the rate of \$ _____ each month until my debt is paid in full. These payments will begin on _____.

Signed,

Consumer _____ Date _____

Case Manager _____ Date _____

SAIL Care Coordinator _____ Date _____

Checks should be made payable to:
Milwaukee County
Behavioral Health Division,
SAM FUND and payments sent to:

Milwaukee County Behavioral Health Division SAIL Unit
Attention: Jena Scherer
9201 Watertown Plank Road
Milwaukee WI 53226