



Resource Mothers Program  
REQUEST FOR PAYMENT-PSYCHOLOGICAL TESTING

Name: \_\_\_\_\_

Social Security # \_\_\_\_\_

Mailing Address where check will be sent:

Phone: \_\_\_\_\_

Date of Request: \_\_\_\_\_

Please check all that apply:

\_\_\_\_\_ (WAIS-R) III Testing -mother (\$250)

\_\_\_\_\_ Bayley and HOME Inventory - infant (\$250)

\_\_\_\_\_ Mileage Expense

Total Miles \_\_\_\_\_ x \$0.345 cents/mile = \_\_\_\_\_

Total Amount Requested: \_\_\_\_\_

Mail this form to:  
Maternal PKU Program  
Children's Hospital, Boston  
300 Longwood Ave  
IC Smith 106  
Boston, MA 02115  
Attn: Melissa Gennaccaro

Or FAX to:  
(617) 734-2652  
Attn: Melissa Gennaccaro

\_\_\_\_\_  
For office use only

Date submitted to accounting \_\_\_\_\_