995 Worthington Street, Springfield, MA 01109
Telephone 413-734-5376 FAX 413-737-7949

# STOP PAYMENT REQUEST FORM

I request Mental Health Association Inc. issue a stop payment on my check dated_____ in the amount of $_____. I understand I am responsible for any stop payment fees incurred by MHA, and that these amounts will be deducted from my check when it is reissued.

Signed_____

Dated_____