DEPARTMENT OF HEALTH AND MENTAL HYGIENE
DEVELOPMENTAL DISABILITIES ADMINISTRATION FUNDING PROPOSAL
REQUEST FOR PAYMENT - VENDOR INVOICE - DHMH DDA 437 FORM

1) VENDOR NAME _____
2) VENDOR ADDRESS _____
3) CITY/STATE/ZIP _____
4) PROJECT TITLE _____
5) TELEPHONE NUMBER _____
6) DIRECTOR'S NAME _____
7) FEDERAL EMPLOYER ID _____

8) STATE FISCAL YEAR : _____
9) CONTRACT AWARD #: _____
10) REQUESTING PERIOD:
TO _____

By my signature, I attest that this information is correct, that the requested payment is just and correct and that payment for the same services/period have not been requested previously.

11) SIGNATURE _____ (Blue Ink) DATE _____

PART A. VENDOR'S REQUEST SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES AGREEMENT

Amount of DDA Award $ _____

Total Payment Request - Part A $ _____

PART B. DHMH SUBPROVIDER BUDGET REVIEW ATTESTATION (FOR DHMH USE ONLY)

We have reviewed and maintain on file, documentation of the DHMH subprovider budgets included in the purchase of service line item in the DHMH provider budget for this human service agreement or have a similar assurance by the vendor of record on file.

DHMH Funding Administration Representative _____ (Print Name) _____ (Signature)

Date _____

NOTE: *The above attestation is required before any invoice, after and including the October(quarterly) or November (bi-monthly) vendor invoice, can be paid by the Division of Program Cost and Analysis.*

PART C. DDA APPROVAL (FOR DDA USE ONLY)

Amount of DDA Payment $ _____

Approved By _____

Date _____

PART D. DHMH PAYMENT (FOR DPCA USE ONLY)

Amount of DDA Payment $ _____

Approved By _____

Date _____

Exempt under Annotated Code of Maryland, State Finance and Procurement Article §11.203(a)(1)(xix)