DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HUMAN SERVICE AGREEMENT
REQUEST FOR PAYMENT - VENDOR INVOICE - DHMH 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. Award - Human Service Agreement

Amount of Human Services Award $ _____

Amount of CSA Administrative Award $ _____

PART B. Vendor's Request - Human Service Agreement

Amount of Human Services Award Request $ _____

Amount of CSA Administrative Request $ _____

Total Payment Request $ _____

PART C. 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 D. DHMH PAYMENT (FOR DHMH USE ONLY)

Amount of Human Services Payment $ _____

Amount of CSA Administrative Payment $ _____

Total Approved Payment $ _____

Approved By _____

Date _____

Notes: _____