

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

**Division of Services for People with Disabilities  
One-Time Payment Form**

This form is to be used only for onetime payments for service codes EA1, EA2, SM1, SM2, and MAG.

1) Date Form Completed: (mm/dd/yy)		2) Consumer PID#:		3) Consumer Name:	
4) Provider ID:		5) Provider Name:			
6) Description of Services:					
7) Consumer PCSP End Date: (mm/dd/yy)					
8) Service Code:	9) Kind of Unit:	10) Unit Amount:	11) Eligibility:	12) Payment Amount:	
13) Payment Start Date: (mm/dd/yy)	14) Payment End Date: (mm/dd/yy)	15) Office Code:		Payment Tech Initials:  Date Initialed: (mm/dd/yy)	
16) Payment Tech Information (PLEASE PRINT)					
Name:			Email:		
By signing below I certify to the best of my knowledge that Department, State Finance, and Purchasing requirements have been properly followed.					
<b>Administrative Service Manager Approval:</b>					
_____		_____		_____	
Name (Please Print)		Signature		Date	
<b>Support Coordinator Approval:</b>					
_____		_____		_____	
Name (Please Print)		Signature		Date	
I certify the services listed on this statement will be rendered on behalf of the above named persons, the above amount constitutes the full and complete charge for said services described above, that I will make no further claim for payment of these services, and that these services will be provided without discrimination based upon race, color, creed, sex, handicap, or national origin.					
<b>Provider Approval:</b>					
_____		_____		_____	
Name (Please Print)		Signature		Date	
To the best of my knowledge, the one-time payment process has been followed, the invoice has been matched with the 295 CAPS Form, and the payment is ready to be entered into CAPS.					
<b>DSPD Contract Team:</b>					
_____		_____		_____	
Name (Please Print)		Signature		Date	