DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

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

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) Service Start Date: (mm/dd/yy)	14) Service End Date: (mm/dd/yy)	15) Office Code:	Payment Tech Initials: Date Initialed: (mm/dd/yy)

16)Payment Tech Information (PLEASE PRINT)

Name: Email:

I certify to the best of my knowledge that Department, State Finance, and Purchasing requirements have been properly followed.

Administrative Service Manager Approval:

_____

Name (Please Print) Signature Date

I certify the DSPD One-time Payment Process has been followed. I agree to confirm and notify DSPD after the service(s) have been provided. By notifying DSPD after the service(s) have been provided, I authorize payment, and I certify the service(s), to the best of my knowledge, were fully provided. I also certify that I am the person responsible to authorize payment.

Support Coordinator Approval:

_____

Name (Please Print) Signature Date

I certify the services listed on this statement will be rendered on behalf of the above named individual; this claim constitutes the full and complete charge for services described above; and I will make no further claim for payment of these services.

Provider Approval:

_____

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.

DSPD Contract Team:

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Name (Please Print) Signature Date