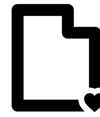

Utah Department of
Health & Human Services
Services for People with Disabilities

ONE-TIME PAYMENT

Form: 295 CAPS

Version Date: January 2024

General Information

Person's Name: PID Number:

Provider Name: Provider ID:

Description of Services:

Budget Information

PCSP End Date: RFS Number: Office Code: Eligibility:

Service Code: Start Date: End Date:

Unit Kind: Number of Units: Unit Dollar Amount: $

Total Payment Amount: $

Signatures

PROVIDER

Name:

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.

Signature: Date:

DSPD ADMINISTRATIVE SERVICE MANAGER

Name:

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

Signature: Date:

DSPD PROGRAM MANAGER

Name:

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.

Signature: Date: