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

ONE-TIME PAYMENT

Form: 295 CAPS
Version Date: January 2024

Privacy Notice: See the end of this form to learn why DHHS collects this personal data

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: _____

Privacy Notice:
DHHS is collecting this personal data to process a one-time payment. It will only be used by DHHS and, if needed, by a person or party contracted with DHHS. Without this data, we cannot make a one-time payment. This data is part of record series: 15376.