



ONE-TIME PAYMENT

Form: 295 CAPS

General Information

Person's Name:

PID Number:

Provider Name:

Provider ID:

Description of Services:

Budget Information

PCSP End:

RFS Number:

Office Code:

Eligibility:

Service:

Start:

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 individuals or parties contracted with DHHS. Without this data, we cannot make a one-time payment. This data is part of record series: 15376.