## Department of Health & Human Services – Office of Aging & Disability Services

**Authorized Payment Information Form**

This form is to accompany any request for service that will require payment to a vendor, or pass through agency for the purchasing of devices, goods, services or other items in Section 21 and 29 if authorized.

|  |  |
| --- | --- |
| **Client Name**: Click or tap here to enter text. | **Client EIS #:** Click or tap here to enter text. |
| **Case Manager**: Click or tap here to enter text.**CM Agency**: Click or tap here to enter text. | **CM Email**: Click or tap here to enter text.**CM Phone #:** Click or tap here to enter text. |
| **Payment is for which service (s)**:[ ]  Specialized Medical Equipment (SME) [ ]  Assistive Technology (AT) – Devices & Transmission[ ]  Communication Aids, Devices or services [ ]  Other (indicate): Click or tap here to enter text. |
| **CRT Use Only *(Cross out & initial any denied items)***Date received: Click or tap to enter a date.Date of Approval:Click or tap to enter a date.CRT Initials: | **RC Use Only:**Date received: Click or tap to enter a date.Date of Authorization: Click or tap to enter a date.RC Initials: |

**ITEMS OR SERVICES TO BE PURCHASED**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Item # | Name of Item: | Item Cost | Quantity | Total for Line |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
|  |  |  | Sales Tax: | Click or tap here to enter text. |
|  |  |  | Total Cost: | Click or tap here to enter text. |

Total to be Paid to Vendor/Provider: Click or tap here to enter text.

**PAYMENT INFORMATION**:

Vendor/Provider Name (not program name): Click or tap here to enter text.

Vendor/Provider Billing Location (EIS Location): Click or tap here to enter text.

Vendor/Provider Program Contact Information (Name & Email): Click or tap here to enter text.

Vendor/Provider Billing Contact Information (Name & Email): Click or tap here to enter text.

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Signature of Case Manager Date: