## 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: