



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
VENDOR REQUEST FOR PAYMENT

VENDOR USE			
VENDOR NAME		INVOICE NUMBER	
VENDOR REMIT TO ADDRESS			
STATE VENDOR NUMBER		BILLING PERIOD	
CONTRACT NAME / SERVICE Child Care Sanitation Program Inspections		CONTRACT NUMBER ERS220-	AMOUNT REQUESTED
COMMENTS			
I CERTIFY THAT THIS REPORT IS TRUE AND THAT ALL PAYMENTS CLAIMED ARE IN ACCORDANCE WITH THE PROVISIONS SET FORTH IN THE CONTRACT.			
AUTHORIZED SIGNATURE 		TITLE	DATE
FOR DHSS PROGRAM USE ONLY			
PURCHASE ORDER (SC, SCS DOCUMENT NUMBER)		RECEIVER DOCUMENT (RC) NUMBER	
PROGRAM / BUREAU APPROVAL SIGNATURE(S)		TITLE	DATE APPROVED
COMMENTS			
ACCOUNTING DISTRIBUTION			DATE STAMP, ETC.
SC, SCS ACCOUNTING LINE NO.	AMOUNT	PLEASE CIRCLE ONE PARTIAL (P) FINAL (F)	
		P F	
		P F	
		P F	
		P F	
		P F	
APPROVED PAYMENT AMOUNT			
ACCOUNTS PAYABLE SIGNATURE 			DATE PROCESSED