

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
HUMAN SERVICE AGREEMENT  
REQUEST FOR PAYMENT - VENDOR INVOICE - DHMH 437 FORM**

|                              |                              |
|------------------------------|------------------------------|
| 1) VENDOR NAME _____         | 8) STATE FISCAL YEAR : _____ |
| 2) VENDOR ADDRESS _____      |                              |
| 3) CITY/STATE/ZIP _____      | 9) CONTRACT AWARD #: _____   |
| 4) PROJECT TITLE _____       |                              |
| 5) TELEPHONE NUMBER _____    |                              |
| 6) DIRECTOR'S NAME _____     | 10) REQUESTING PERIOD: _____ |
| 7) FEDERAL EMPLOYER ID _____ | TO _____                     |

*By my signature, I attest that this information is correct, that the requested payment is just and correct and that payment for the same services/period have not been requested previously.*

11) SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(Blue Ink)

**PART A. Award - Human Service Agreement**

Amount of Human Services Award \$ \_\_\_\_\_

Amount of CSA Administrative Award \$ \_\_\_\_\_

**PART B. Vendor's Request - Human Service Agreement**

Amount of Human Services Award Request \$ \_\_\_\_\_

Amount of CSA Administrative Request \$ \_\_\_\_\_

Total Payment Request \$ \_\_\_\_\_

**PART C. DHMH SUBPROVIDER BUDGET REVIEW ATTESTATION (FOR DHMH USE ONLY)**  
*We have reviewed and maintain on file, documentation of the DHMH subprovider budgets included in the purchase of service line item in the DHMH provider budget for this human service agreement or have a similar assurance by the vendor of record on file.*

DHMH Funding Administration Representative \_\_\_\_\_ (Print Name) \_\_\_\_\_ (Signature)

Date \_\_\_\_\_

**NOTE:** *The above attestation is required before any invoice, after and including the October(quarterly ) or November (bi-monthly) vendor invoice, can be paid by the Division of Program Cost and Analysis.*

**PART D. DHMH PAYMENT (FOR DHMH USE ONLY)**

Amount of Human Services Payment \$ \_\_\_\_\_

Amount of CSA Administrative Payment \$ \_\_\_\_\_

Total Approved Payment \$ \_\_\_\_\_

Approved By \_\_\_\_\_

Date \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_