|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PAYMENT REQUEST | | | | | | | | | | | | | | | | |
| Michigan Department of Health and Human Services | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **DOCUMENT INFORMATION (For MDHHS Accounting Use Only)** | | | | | | | | | | | | | | | | |
| Code | | Unit | | | ID | | | | Pre-Audit By | | Entered By | | | Approved By | | |
|  | |  | | |  | | | |  | |  | | |  | | |
| **DOCUMENT INFORMATION** | | | | | | | | | | | | | | | | |
| Case Name | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **HEADER INFORMATION** | | | | | | | | | | | | | | | | |
| Document Description | | | | | | | | | | | | | | | | |
| COVID Prevention and Reunification Eligible Specific Assistance Reimbursment | | | | | | | | | | | | | | | | |
| Extended Description (if applicable) | | | | | | | | | | | | | | | | |
| Per Communication Issuance 20-080 | | | | | | | | | | | | | | | | |
| Print/Type Name of Case Worker | | | | | | | | Signature of Case Worker | | | | | | | | Date |
|  | | | | | | | |  | | | | | | | |  |
| Print//Type Name of Supervisor | | | | | | | | Signature of Supervisor | | | | | | | | Date |
|  | | | | | | | |  | | | | | | | |  |
| **VENDOR INFORMATION** | | | | | | | | | | | | | | | | |
| Vendor/Customer Code | | | | | | Vendor/Customer Name | | | | | | | Address Code | | | |
|  | | | | | |  | | | | | | |  | | | |
| Vendor/Customer Address Line 1 | | | | | | | | | Vendor/Customer Address Line 2 | | | | | | | |
|  | | | | | | | | |  | | | | | | | |
| City | | | | State | | | Zip Code | | Single Payment | | | Central Office Print | | | | |
|  | | | |  | | |  | | Yes | No | | Yes | | | No | |
| **COMMODITY INFORMATION** | | | | | | | | | | | | | | | | |
| Commodity | | | | | | | | | CS-138 | | | | | | | |
|  |  | | | | | | | |  | | | | | | | |
|  |  | | | | | | | |  | | | | | | | |
| **ACCOUNTING INFORMATION** | | | | | | | | | | | | | | | | |
| Invoice Number | | | Check Description | | | | | | | | | | | | | |
|  | | | COVID 19 Specific Assistance Reimbursment | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BFY | | Accounting Template | Unit | Dept.  Object | Dept.  Revenue | Line Amount |
|  | 20 | 491XX1302 | 3JG |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | | | | | | 0.00 |

|  |  |  |
| --- | --- | --- |
| Email Contact | | |
| rostonin@michigan.gov | | |
| Print/Type Name of MDHHS Employee | Signature of MDHHS Employee | Date |
|  |  |  |
| Print/Type Name of MDHHS PAL | Signature of MDHHS PAL | Date |
| Nancy Rostoni |  |  |

**Instructions for Completion of the MDHHS-5602**

Incomplete or improperly completed forms may be returned to the preparer for completion. This form is to be completed internally by an employee of the State of Michigan MDHHS. Authorized signer is stating they have reviewed entire document and approve. No change may be made once this has been signed.

**DOCUMENT INFORMATION** – To be completed by the preparer (if client related).

**Case Name:** Case name from the appropriate system (i.e., Bridges).

**HEADER INFORMATION** – To be completed by the preparer.

**Document Description:** Reason for the payment request.

**Extended Description (if applicable):** Additional information needed for the payment request.

**Name/Signature of Case Worker** – applicable only if client-based payment

**Name/Signature of Supervisor** – applicable only if client-based payment

**VENDOR INFORMATION** – To be completed by the preparer (all information obtained from SIGMA VCUST).

**Vendor/Customer Code:** SIGMA vendor number used to make payment (this is not a FEIN)

**Vendor/Customer Name:**  Legal name of vendor where payment should be sent.\*

**Address Code:** Number associated with the address where the payment is to be sent. \*

**Vendor/Customer Address Line 1:** Address where the payment is to be sent.\*

**Vendor/Customer/Grantee Address Line 2:** Additional information regarding the address. \*

**City:** City where the payment is to be sent. \*

**State:** State where the payment is to be sent. \*

**Zip Code:** Zip Code where the payment is to be sent.\*

\*Note: Address must match remit to address on documentation attached.

**Single Payment (Y/N):** If this payment needs to be paid as standalone to the vendor mark yes. This payment will not be consolidated with other payments disbursed on the same day to the vendor.

**Central Office Print (Y/N):** Payment request to produce check printed in central office and distributed to requestor.

**COMMODITY INFORMATION** – To be completed by the preparer (if applicable).

**Commodity Code:** May be found in SIGMA Commodity Table (COMM).

**CS-138:** May be found in SIGMA CS-138 table.

**ACCOUNTING INFORMATION** – To be completed by the preparer.

**Invoice Number:** Number used to identify payment to the vendor (if none, leave blank).

**Check Description:** Information to be printed on the remittance advice to allow vendor to identify.

**BFY:** Budget Fiscal Year to be used on payment.

**Accounting Template:** Enter code that needs to be used to allocate the funds properly for payment

**Unit:** Identifies the MDHHS area charged for the expenditure.

**Dept Object:** Leave this blank – completed by central office Accounts Payable.

**Dept Revenue:** Coding used on revenue refunds.

**Line Amount:** Enter for each amount distributed between accounting templates

**Contact email:** Enter who should be contacted for questions from accounting.

**Name of MDHHS Employee:** Individual preparing the document (must print and sign).

**MDHHS PAL:** Person Authorized by MDHHS to sign for that amount and location of services -final approval for payment to be made (must print and sign).

Questions regarding this form can be emailed to [invoicemdhhs@michigan.gov](https://stateofmichigan.sharepoint.com/teams/insidedhhs/work/formsandpolicies/FormsLibrary/invoicemdhhs@michigan.gov).