THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Michael R. Bloomberg
Mayor
Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

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Lloyd I. Sederer, M.D.
Executive Deputy Commissioner
Mental Hygiene Services

INSTRUCTIONS FOR COMPLETION OF

SAMPLE LETTER OF SIGNATURE AUTHORIZATION
And
CLAIM FOR ADVANCE PAYMENT

Letters of Signature Authorization and Claim for Advance Payment forms MUST be typed on your Agency Letterhead. All signatures and Notary stamps must be clear originals.

The number of people authorized to authenticate and certify documents and schedules is left to the discretion of your Agency's Board of Director's designees. However, at least two signatories are advisable. The letter of Signature Authorization must be accompanied by a copy of the most recent Agency's Board of Directors' resolution authorizing the signatory for the Agreement. The Department should be notified immediately when or if a signatory's authority becomes invalid for any reason.

Claims for Advance Payments requests (one for each advance) must be submitted to the Department to avoid delays in advance payments. The Agency should refer to the payment clause in the Agreement to determine the maximum amount allowed for each advance.

Should you have any additional questions regarding the completion of either the Letter of Signature Authorization or the Claim for Advance payment, please contact your contract portfolio team member.

SAMPLE LETTER OF SIGNATURE AUTHORIZATION
(TO BE PRINTED ON AGENCY LETTERHEAD)

DATE: _____

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
93 WORTH STREET - ROOM 200A
NEW YORK, NY 10013

I HEREBY AUTHORIZE:

NAME_____ **TITLE:**_____

_____
SIGNATURE SPECIMEN

NAME_____ **TITLE:**_____

_____
SIGNATURE SPECIMEN

NAME_____ **TITLE:**_____

_____
(*SIGNATURE SPECIMEN*)

whose specimen signature(s) appear(s) above to authenticate and certify claims for payment and other related documents and schedules under the provisions of the Agreement Department Number [COPY FROM AGREEMENT] between the City of New York, acting by and through the Department of Health and Mental Hygiene, and [INSERT NAME OF THE AGENCY AS IT APPEARS IN THE AGREEMENT], for the services to be provided during the period from [INSERT EFFECTIVE START DATE OF AGREEEMNT SCHEUDLES] to [INSERT EFFECTIVE AND DATE OF AGREEMENT/SCHEDULES].

State of New York

_____
(Signature of Agency Official)

County of

_____
(Type Name)

this Day of 200___

_____
(Notary Public)
Affix Notary Stamp

ADVANCE PAYMENT CLAIM FORM
(TO BE PRINTED ON AGENCY LETTERHEAD)

DATE:_____

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
93 WORTH STREET - ROOM 200A
NEW YORK, NY 10013

NAME OF PROVIDER AGENCY _____

DEPARTMENT # _____

ADVANCE PAYMENT # _____

FOR MONTH OF: _____ **20**_____

I hereby certify an advance payment in the amount of $_____is due and payable to this Agency and is being claimed under the provisions of the Agreement between the City of New York acting by and through the Department of Health and Mental Hygiene, and [INSERT AGENCY NAME AS IT APPEARS IN THE AGREEMENT] under Agreement Department Number [INSERT DEPARTMENT NUMBER], that this Agreement has been duly executed; and that no part of the amount claimed above has been previously included in a claim to the City of New York.

_____
(Authorized Agency Signature)

_____
(Type Name)

_____
(Title of Agency Official)