

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
DEVELOPMENTAL DISABILITIES ADMINISTRATION FUNDING PROPOSAL  
REQUEST FOR PAYMENT - VENDOR INVOICE - DHMH DDA 437 FORM**

1) VENDOR NAME \_\_\_\_\_  
2) VENDOR ADDRESS \_\_\_\_\_  
3) CITY/STATE/ZIP \_\_\_\_\_  
4) PROJECT TITLE \_\_\_\_\_  
5) TELEPHONE NUMBER \_\_\_\_\_  
6) DIRECTOR'S NAME \_\_\_\_\_  
7) FEDERAL EMPLOYER ID \_\_\_\_\_

8) STATE FISCAL YEAR : \_\_\_\_\_  
9) CONTRACT AWARD #: \_\_\_\_\_  
10) REQUESTING PERIOD:  
\_\_\_\_\_ 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 \_\_\_\_\_  
(Blue Ink)

DATE \_\_\_\_\_

**PART A. VENDOR'S REQUEST SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES AGREEMENT**

Amount of DDA Award \$ \_\_\_\_\_

Total Payment Request - Part A \$ \_\_\_\_\_

**PART B. 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 C. DDA APPROVAL (FOR DDA USE ONLY)**

Amount of DDA Payment \$ \_\_\_\_\_

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

Date \_\_\_\_\_

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

Amount of DDA Payment \$ \_\_\_\_\_

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

Date \_\_\_\_\_

**Exempt under Annotated Code of Maryland, State Finance and Procurement Article §11.203(a)(1)(xix)**