



Veteran Directed Care Goods and Services Payment Request Form

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|-------------------------------------|------------------------------|
| Veteran Name | Acumen ID # |
| Employer Name (if different) | Month/Year of Invoice |

Employer Reimbursement
 Direct to Vendor Payment

Check or Direct Deposit Payment Instructions

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|--|------------------------------------|
| Make Payment To (Vendor/Employer Name): | |
| Vendor/Employer Address | |
| Vendor/Employer City/State/Zip | Vendor/Employer FEIN or SS# |
| If online purchase ship to Name: | Address: |

| Invoice/ Service Date | Service Code* | Spending Plan Description | Description of Service (e.g. Incontinence supplies, Adult Day Service, Home modifications, etc) | Total Amount |
|-----------------------|---------------|---------------------------|---|--------------|
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| | | | Total Check Amount | |

By signing this form, I attest that services were delivered and received consistent with the Veteran Spending Plan and I have rendered and/or approved this payment request in accordance with the Program regulations. I understand that payment and satisfaction of this claim may be from Federal and State funds, and that I may be prosecuted under applicable Federal or State laws for any false claims, statements or documents or concealment of a material fact. Any misuse of funds may result in being fined or penalized, including but not limited to my repayment of claim.

Case Manager Signature

Date

This form should be completed and submitted by your Case Manager. To begin the Vendor Payment or Employer Reimbursement process, reach out to your assigned Case Manager.