

# Request for Vendor Payment/Reimbursement Form



<b>Veteran Name</b>	<b>Veteran ID #</b>
<b>Employer Name</b>	<b>Month/Year of Service</b>

## Payment Instructions

<b>Make Check Payable To:</b>	
<b>Vendor FEIN or SS#</b>	<b>Vendor Name</b>
<b>Vendor Address</b>	<b>Vendor City/State/Zip</b>

Please pay from:

☐ Goods/Services (VEND)      ☐ Emergency Backup (EMER)      ☐ Savings Funds (SAVE)

Invoice/ Service Date	Service Code	Description	Total Amount
		<b>Total Check Amount</b>	
		<b>Invoice Number</b>	

**REMINDER:** Please attach a copy of the receipt or invoice.

By signing this form, I attest that services were delivered and received consistent with the Spending Plan and I have rendered and/or approved the above 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 the repayment of claim. Collection costs or legal fees will be my responsibility.

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

If I am requesting payment out of the Savings Funds or Emergency Backup Fund, this form must also be signed by a representative of the Maryland Department of Aging.

\_\_\_\_\_  
Maryland Department of Aging Signature

\_\_\_\_\_  
Date

Return completed form to Acumen (choose one option):

Email: [customerservice@acumen2.net](mailto:customerservice@acumen2.net)

Mail: 5416 E Baseline Rd., Suite 200, Mesa, AZ 85206

Fax: (855) 275-8038