



EMPLOYEE NAME (LAST NAME, FIRST NAME)

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EMPLOYEE ID

INDIVIDUAL IN SERVICE NAME (LAST NAME, FIRST NAME)

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INDIVIDUAL AWACS ID

Signing this form, I attest that services were delivered and received consistent with the Individual Cost 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 the repayment of claim. Collection costs or legal fees will be my responsibility.

Employee Signature

Date

Employer Signature

Date

[illegible]