

TRAINING GRANT
MT SDEO Request for Payment or Reimbursement Form



**** TRAINING GRANT APPROVAL LETTER MUST BE SENT WITH THIS FORM**

1. Participant Name:	2. Participant Last 4 SSN #:
3. Employer/Authorized Rep Name:	4. Month/Year:

5. Payment Instructions: (Mark One) This is a Reimbursement [] This is a Vendor Payment []

6. Make Check Payable To:	
7. Vendor Payment - Business/Agency FEIN or Reimbursement - Employer/Auth Rep SS#:	8. Business Name If different than #6:
9. Address:	10. City/State/Zip:

11. Invoice/ Service Date	12. Service Code	13. Description: This Request for Payment Form is ONLY for the payment of Training Grants. W-9 for Vendor must be on file with Acumen or attached to this request.	14. Total Amount
	Training Grant		
		15. Total Check Amount	

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

By signing this form, I attest that services were delivered and received consistent with the Training Grant Approval 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. I understand that Medicaid is the payer of last resort.

_____	_____	_____	_____
Employer or AR Signature	Date	Case Manager's Signature	Date

Return completed form with copy of the receipt or invoice to 5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206 or FAX to (866) 211-6370.