MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - HOME VISITING

VENDOR REQUEST FOR PAYMENT - SAFE CRIBS PROGRAM

FAX: 573-751-6185

INSTRUCTIONS

Please fill out form completely and send to childhoodinvoices@dese.mo.gov.

VENDOR USE

VENDOR NAME *(must match MissouriBUYS / SAM II)*

INVOICE NUMBER *(SAFCRB followed by up to 6 numbers and/or letters. Cannot exceed 12 characters. No spaces or hyphens.)*

VENDOR REMIT TO ADDRESS *(must match your address in MissouriBUYS / SAM II)*

STATE VENDOR NUMBER *(the same vendor number you use for other state invoicing – must match MissouriBUYS / SAM II)*

BILLING PERIOD *(Bill within 30 days after completion of services)*

CONTRACT NAME / SERVICE	CONTRACT NUMBER	AMOUNT REQUESTED
Safe Cribs for Missouri - for providing infant safe sleep education to families who receive a crib from the Safe Cribs for Missouri program		

COMMENTS *(Please fill in and check appropriate boxes. One client per invoice.)*

Client's name: _____

Date initial education provided: _____

- ☐ in the office..... $50
- ☐ in the client's home $75

Date follow-up education provided: _____

- ☐ in the client's home.....$75
- ☐ in the office or by phone $50
- ☐ unable to provide follow-up..... $0

ADDITIONAL COMMENTS, IF REQUIRED
PLEASE STATE REASON FOLLOW-UP WAS NOT PROVIDED:

I CERTIFY THAT THIS REPORT IS TRUE AND THAT ALL PAYMENTS CLAIMED ARE IN ACCORDANCE WITH THE PROVISIONS SET FORTH IN THE CONTRACT.

AUTHORIZED SIGNATURE	TITLE	DATE

FOR DESE PROGRAM USE ONLY

PURCHASE ORDER (SC, SCS, DOCUMENT NUMBER)	RECEIVER DOCUMENT (RC) NUMBER

PROGRAM / BUREAU APPROVAL SIGNATURE(S)	TITLE	DATE APPROVED

COMMENTS

ACCOUNTING DISTRIBUTION

SC, SCS, ACCOUNTING LINE NO.	AMOUNT	PLEASE CIRCLE ONE PARTIAL (P)	FINAL (F)
		P	F
		P	F
		P	F
		P	F
		P	F
APPROVED PAYMENT AMOUNT			

DATE STAMP, ETC.

ACCOUNTS PAYABLE SIGNATURE	DATE PROCESSED

MO 500-3271 (12-23)