AUTHORIZATION/RECEIPT FOR DIRECT PAYMENT

I. The ___________________________________________________________ County Department of Social Services hereby authorizes ______________________________________________________ (name of provider) to deliver/provide ______________________________________________________ (description of service/item) to the individual identified in Section II. below. As the provider, I agree not to collect any additional fee charge from the recipient for the service/item authorized and will keep confidential any information about a client which is shared by the Department or client.

Name of Recipient: ____________________________________________

II. a. Recipient ID #: ____________________________________________
   b. Service/Resource Item Code: ________________________________
   c. Primary Service Code if Different: ___________________________
   d. Period of Authorization: From: ____________________ 19__________ through ________________ 19 ___________.

III. The provider is authorized to claim payment for service/item described in Section I. above at a cost of $ _______________ per __________________________ (unit) for an amount not to exceed __________________________. A bill for the service is to be submitted along with this form. The county department of social services will reimburse the provider by check within thirty days of receipt of a correctly completed request.

IV. County Department of Social Services

   Signature: ____________________________  Title: ____________________________
   Address: ____________________________ Date: ____________________________

V. Provider

(  ) a. A detailed bill is attached for service/resource item provided to the individual; or,

(  ) b. In lieu of a bill, I, ____________________________________________, hereby certify that I have provided ____________________________________________, (description of what was purchased/provided) on __________________________ (date/s) to the recipient named above at a cost of $ ____________________________.

   Signature: ____________________________  Title: ____________________________
   Address: ____________________________ Date: ____________________________

VI. Amount of Payment: $ ____________________________  Date __________________ Check #_________

INSTRUCTIONS FOR COMPLETION AND DISTRIBUTION OF THE DSS-6852 (Rev. 7/93)

A representative of the DSS completes Sections I-IV of this form in duplicate. Send an original to the service provider and keep a copy for the client record. The provider completes Section V. and submits any attachments required by the county department of social services. Section VI is completed by the appropriate DSS staff person when reimbursement to the provider is made.

DSS-6852 (Rev. 7/93)

Budget/Contracts