

SWISSPORT

2150 SMITHTOWN AVE, SUITE 4, RONKONKOMA, NY 11779

Phone 516-433-4500

PARENT MILEAGE REIMBURSEMENT PROGRAM

Date: _____

Child's Name: _____

Address: _____

Dear Parent/Guardian:

Welcome to the Parent Mileage Reimbursement Program for Nassau County. This Mileage Reimbursement packet contains the necessary claim forms and instructions for submitting your claims.

- When submitting your PMR claims, please print all information clearly. This will help expedite claims for payment.
- Reimbursement will be paid at the Federal rate per mile for one trip to **and** one trip from the service provider daily (i.e., only one round trip per day).
- The number of miles from a child's legal address to the service provider will be determined by utilizing MapQuest only, which Swissport will calculate.
- Parent/Guardian MUST drive the child on a consistent basis.
- Parent/Guardian MUST have the dates on the Mileage Reimbursement Attendance Form validated by a Service provider representative.
- Only the authorized Parent is permitted to fill out the Parent Mileage Reimbursement forms.
- Complete Nassau County Claim Vouchers (see attached). You MUST submit a Claim Voucher for each Mileage Reimbursement Attendance Form.
- Complete Nassau County Request for Taxpayer Form (#700-W9 Revised October 2019):
**A blank voided check must be attached to the Taxpayer Form if electronic payment (direct deposit) is requested. The Taxpayer Form only needs to be submitted once, unless any bank changes are made.
- Completed Claim Voucher forms are to be mailed no later than fifteen (15) calendar days after the end of the period for which the claim is being made (for example, the Claim Voucher form for April-June must be mailed to this office by July 15).

If you have any questions, please do not hesitate to contact Swissport at 516-433-4500 or 631-737-0600.

Sincerely,

Swissport Mileage Reimbursement Examiners

SWISSPORT

2150 SMITHTOWN AVE, SUITE 4, RONKONKOMA, NY 11779

Phone 516-433-4500

PARENT MILEAGE REIMBURSEMENT PROGRAM

INSTRUCTIONS FOR ALL FORMS:

MILEAGE REIMBURSEMENT ATTENDANCE FORM (Submitted Quarterly)

| TOP SECTION | MIDDLE SECTION | BOTTOM SECTION |
|---|---|---|
| -Child's Name -Legal Address -Child's Date of Birth -Name of Service Provider -Service Provider Location -Check Early Intervention or Preschool | Circle each date in each month you transported your child to and from the approved Service Provider. The Service Provider must circle dates, print, and sign their section. | -Signature of Parent/Guardian -Date of Signature -Valid Phone Number -Legibly Printed Parent/Guardian Name -Social Security Number of Parent Claiming Reimbursement |

COUNTY OF NASSAU CLAIM VOUCHER FORM (Submitted Quarterly)

Parents/Guardians are responsible for completing SECTIONS 4,6,7 & 8 on the Nassau County Claim Voucher

| SECTION 4 | SECTION 6 | SECTION 7 | SECTION 8 |
|---|----------------------|-----------------|---|
| Parent/Guardian Social Security Number | Parent/Guardian Name | Mailing Address | Legibly printed Parent/Guardian name and sign |

** Please fill out 4,6,7 & 8 only. Failure to do so will cause claim to be returned, unprocessed and will cause a delay in your reimbursement. **

NASSAU COUNTY REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION FORM

(Submitted once unless information changes)

| SECTION I-VENDOR INFORMATION | SECTION II-FINANCIAL INSTITUTION INFORMATION |
|--|---|
| *(PARENT CLAIMING REIMBURSEMENT IS THE VENDOR) Fill out numbers 1 through 7. #12 – Check box if you would prefer to receive a paper check. #14 – Sign, Print and Date form. | If you would like to be paid electronically (DIRECT DEPOSIT), fill out this section and include a Voided Check. |

Please include all three forms when submitting. Taxpayer form should only be submitted once. Mileage Reimbursement attendance form must always be accompanied with a claim voucher form.

If you have any questions, please do not hesitate to contact Luz or Brigid at 516-433-4500 or 631-737-0600.

Please send the requested documents to the following address:

Swissport

2150 SMITHTOWN AVE, SUITE 4

RONKONKOMA, NY 11779

Attn: Mileage Reimbursement Program

**NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT ATTENDANCE FORM**

CHILD'S NAME: _____ CHILD IS: _____
 ADDRESS: _____ Early Intervention (Birth to 2yrs & 11 mos.)
 SERVICE PROVIDER: _____ EI Auth. #: _____
 SERVICE LOCATION: _____ Preschool Age (3 – 5 years)
 SCHOOL YEAR: _____ NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM: _____

| SEP FOR PARENT/GUARDIAN USE ONLY | OCT FOR PARENT/GUARDIAN USE ONLY | NOV FOR PARENT/GUARDIAN USE ONLY | DEC FOR PARENT/GUARDIAN USE ONLY |
|--|--|--|--|
| 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 |
| FOR SERVICE PROVIDER USE ONLY | FOR SERVICE PROVIDER USE ONLY | FOR SERVICE PROVIDER USE ONLY | FOR SERVICE PROVIDER USE ONLY |
| 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 |
| Verified by: _____ SCHOOL REPRESENTATIVE DATE | Verified by: _____ SCHOOL REPRESENTATIVE DATE | Verified by: _____ SCHOOL REPRESENTATIVE DATE | Verified by: _____ SCHOOL REPRESENTATIVE DATE |
| SCHOOL REPRESENTATIVE TITLE (PRINT) | SCHOOL REPRESENTATIVE TITLE (PRINT) | SCHOOL REPRESENTATIVE TITLE (PRINT) | SCHOOL REPRESENTATIVE TITLE (PRINT) |

This form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar days after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to: **Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, NY 11779.**

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian _____ Date _____ Phone Number _____ Printed Name of Parent/Guardian _____ Social Security # of Parent/Guardian _____
 FOR SWISSPORT USE ONLY _____ X _____ # of Days _____ X 2= \$ _____ Reimbursement Rate _____

**NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT ATTENDANCE FORM**

CHILD'S NAME: _____ DATE OF BIRTH: _____ CHILD IS:
 ADDRESS: _____ SERVICE PROVIDER: _____ Early Intervention (Birth to 2yrs & 11 mos.)
 _____ SERVICE LOCATION: _____ EI Auth. #: _____
 _____ Preschool Age (3 – 5 years)
 CLAIM PERIOD: Jan – Mar SCHOOL YEAR: _____ NUMBER OF DAYS PER WEEK CHILD RECEIVES
 SERVICES OR ATTENDS PROGRAM: _____

| <u>JAN FOR PARENT/GUARDIAN USE ONLY</u> | <u>FEB FOR PARENT/GUARDIAN USE ONLY</u> | <u>MAR FOR PARENT/GUARDIAN USE ONLY</u> |
|--|--|--|
| 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 |
| <u>FOR SERVICE PROVIDER USE ONLY</u> | <u>FOR SERVICE PROVIDER USE ONLY</u> | <u>FOR SERVICE PROVIDER USE ONLY</u> |
| 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 |
| Verified by: _____ SCHOOL REPRESENTATIVE DATE | Verified by: _____ SCHOOL REPRESENTATIVE DATE | Verified by: _____ SCHOOL REPRESENTATIVE DATE |
| SCHOOL REPRESENTATIVE TITLE (PRINT) | SCHOOL REPRESENTATIVE TITLE (PRINT) | SCHOOL REPRESENTATIVE TITLE (PRINT) |

This form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar days after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to: **Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, NY 11779.**

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian _____ Date _____ Phone Number _____ Printed Name of Parent/Guardian _____ Social Security # of Parent/Guardian _____
 FOR SWISSPORT USE ONLY _____ X _____ # of Days _____ X 2= \$ _____ Reimbursement Rate _____

**NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT ATTENDANCE FORM**

CHILD'S NAME: _____ DATE OF BIRTH: _____ CHILD IS:
 ADDRESS: _____ SERVICE PROVIDER: _____ Early Intervention (Birth to 2yrs & 11 mos.)
 _____ SERVICE LOCATION: _____ EI Auth. #: _____
 _____ PRESCHOOL AGE (3 – 5 years)
 CLAIM PERIOD: Apr – June SCHOOL YEAR: _____ NUMBER OF DAYS PER WEEK CHILD RECEIVES
 SERVICES OR ATTENDS PROGRAM: _____

| <u>APR FOR PARENT/GUARDIAN USE ONLY</u> | | | | | | | | | | | | | <u>MAY FOR PARENT/GUARDIAN USE ONLY</u> | | | | | | | | | | | | | <u>JUNE FOR PARENT/GUARDIAN USE ONLY</u> | | | | | | | | | | | | |
|---|----|----|----|----|----|----|----|----|----|----|----|----|---|----|----|----|----|----|----|----|----|----|----|----|----|---|----|----|----|--|--|--|--|--|--|--|--|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | | | | | | | |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | | | | | | | | | |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | | | | | | | | | |
| 31 | | | | | | | | | | 31 | | | | | | | | | | 31 | | | | | | | | | | | | | | | | | | |
| <u>FOR SERVICE PROVIDER USE ONLY</u> | | | | | | | | | | | | | <u>FOR SERVICE PROVIDER USE ONLY</u> | | | | | | | | | | | | | <u>FOR SERVICE PROVIDER USE ONLY</u> | | | | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | | | | | | | |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | | | | | | | | | |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | | | | | | | | | |
| 31 | | | | | | | | | | 31 | | | | | | | | | | 31 | | | | | | | | | | | | | | | | | | |
| Verified by: _____ SCHOOL REPRESENTATIVE _____ DATE _____ | | | | | | | | | | | | | Verified by: _____ SCHOOL REPRESENTATIVE _____ DATE _____ | | | | | | | | | | | | | Verified by: _____ SCHOOL REPRESENTATIVE _____ DATE _____ | | | | | | | | | | | | |
| SCHOOL REPRESENTATIVE TITLE _____ (PRINT) | | | | | | | | | | | | | SCHOOL REPRESENTATIVE TITLE _____ (PRINT) | | | | | | | | | | | | | SCHOOL REPRESENTATIVE TITLE _____ (PRINT) | | | | | | | | | | | | |

This form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar days after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to: **Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, NY 11779.**

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian _____ Date _____ Phone Number _____ Printed Name of Parent/Guardian _____ Social Security # of Parent/Guardian _____
 FOR SWISSPORT USE ONLY One-Way Mileage _____ X # of Days _____ X 2=\$ _____ Reimbursement Rate _____

**NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT ATTENDANCE FORM**

CHILD'S NAME: _____ DATE OF BIRTH: _____ CHILD IS:
 ADDRESS: _____ SERVICE PROVIDER: _____ Early Intervention (Birth to 2yrs & 11 mos.)
 SERVICE LOCATION: _____ EI Auth. #: _____
 SCHOOL YEAR: _____ Preschool Age (3 – 5 years)
 CLAIM PERIOD: July – Aug NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM: _____

| <u>JULY FOR PARENT/GUARDIAN USE ONLY</u> | | | | | | | | | | | <u>AUG FOR PARENT/GUARDIAN USE ONLY</u> | | | | | | | | | | |
|---|----|----|----|----|----|----|----|----|----|--|---|----|----|----|----|----|----|----|----|----|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | |
| 31 | | | | | | | | | | | 31 | | | | | | | | | | |
| <u>FOR SERVICE PROVIDER USE ONLY</u> | | | | | | | | | | | <u>FOR SERVICE PROVIDER USE ONLY</u> | | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | |
| 31 | | | | | | | | | | | 31 | | | | | | | | | | |
| Verified by: _____ | | | | | | | | | | | Verified by: _____ | | | | | | | | | | |
| SCHOOL REPRESENTATIVE _____ | | | | | | | | | | | SCHOOL REPRESENTATIVE _____ | | | | | | | | | | |
| DATE _____ | | | | | | | | | | | DATE _____ | | | | | | | | | | |
| SCHOOL REPRESENTATIVE TITLE _____ (PRINT) | | | | | | | | | | | SCHOOL REPRESENTATIVE TITLE _____ (PRINT) | | | | | | | | | | |

This form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar days after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to: **Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, NY 11779.**

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian _____ Date _____ Phone Number _____ Printed Name of Parent/Guardian _____ Social Security # of Parent/Guardian _____
 FOR SWISSPORT USE ONLY _____ X _____ # of Days _____ X 2= \$ _____ Reimbursement Rate

| | | | | | |
|--|--|--|--|--|--|
| INVOICE NUMBER | | | DOCUMENT # _____ <i>(FOR NASSAU COUNTY DEPARTMENT USE ONLY)</i> | | |
| ORDER /CONTRACT NO. | | | BLANKET ORDER NO. | | |
| VENDOR INFORMATION: NUMBER (9) _____ SUFFIX (2) _____ | | | DISCOUNT AMOUNT _____ | DISCOUNT DATE MO _____ DAY _____ YEAR _____ | |
| NAME (30) _____ (30) _____ ADDR (30) _____ (30) _____ (30) _____ | | | CLAIMANTS CERTIFICATION I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source. | | |
| | | | Claimants Name _____ Date _____ X _____ By (Signature) _____ Title _____ | | |
| DEPT. GOODS OR SERVICES DELIVERED TO | | | | VENDOR'S PAYMENT TERMS | |
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| DATE DELIVERED | ITEMIZATION | UNIT PRICE | AMOUNT |
|---------------------------|-------------|------------|--------|
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| 12 TOTAL CLAIMED ▶ | | | |

For Nassau County Department Use Only:

Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.

| LINE # | INDEX | SUBOBJ | USERCODE | PROJECT | PROJDETAIL | GRANT | GRTDETAIL | G/L ACCOUNT | SUBSIDIARY | AMOUNT |
|---|-------|--------|----------|---------|------------|-----------------------------|-----------|-------------|------------|--------|
| 1 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "invoice no. or claim no." description | | | | | | | | | | |
| 2 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "invoice no. or claim no." description | | | | | | | | | | |
| 3 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "invoice no. or claim no." description | | | | | | | | | | |
| 4 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "invoice no. or claim no." description | | | | | | | | | | |
| NC Department _____ | | | | | | Amount Approved \$ _____ | | | | |
| Contact Person _____ | | | | | | Date _____ | | | | |
| Telephone No. _____ | | | | | | Comptrollers Approval _____ | | | | |

| | | | |
|--|--------------------|--|--|
| INVOICE NUMBER ① _____ | | DOCUMENT # _____ (FOR NASSAU COUNTY DEPARTMENT USE ONLY) | |
| ORDER /CONTRACT NO. ② _____ | | BLANKET ORDER NO. ③ _____ | |
| VENDOR INFORMATION: NUMBER (9) _____ SUFFIX (2) _____ ④ _____ ⑤ _____ | | DISCOUNT AMOUNT _____ | DISCOUNT DATE MO (2) _____ DY (2) _____ YR (2) _____ |
| NAME (30) ⑥ _____ (30) _____ | | CLAIMANTS CERTIFICATION I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source. | |
| ADDR (30) ⑦ _____ (30) _____ (30) _____ | | ⑧ _____ Claimants Name _____ Date _____ X _____ By (Signature) _____ Title _____ | |
| | | DEPT. GOODS OR SERVICES DELIVERED TO ⑨ _____ | VENDOR'S PAYMENT TERMS ⑩ _____ |
| ⑪ DATE DELIVERED | ITEMIZATION | UNIT PRICE | AMOUNT |
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| | | ⑫ TOTAL CLAIMED ▶ | |

For Nassau County Department Use Only:
 NIFS ACCOUNT CODES *Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.*

| LINE # | INDEX | SUBOBJ | USERCODE | PROJECT | PROJDETAIL | GRANT | GRTDETAIL | GL ACCOUNT | SUBSIDIARY | AMOUNT |
|--|-------|---|----------|---------|------------|-------|-----------|------------|------------|--------|
| 1 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): | | FORMAT - "invoice no. or claim no." description | | | | | | | | |
| 2 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): | | FORMAT - "invoice no. or claim no." description | | | | | | | | |
| 3 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): | | FORMAT - "invoice no. or claim no." description | | | | | | | | |
| 4 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): | | FORMAT - "invoice no. or claim no." description | | | | | | | | |

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|--|---|
| NC Department _____ Contact Person _____ Telephone No. _____ | Amount Approved \$ _____ Date _____ Comptrollers Approval _____ |
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|--|---|---|----------------------------|---------|-----------------|---------------|--|
| INVOICE NUMBER | | DOCUMENT # _____ | | | | | |
| ① _____ | | (FOR NASSAU COUNTY DEPARTMENT USE ONLY) | | | | | |
| ORDER /CONTRACT NO. | | BLANKET ORDER NO. | | | | | |
| ② _____ | | ③ _____ | | | | | |
| VENDOR INFORMATION: <table style="width:100%; border: none;"> <tr> <td style="text-align: center; border: none;">NUMBER (9)</td> <td style="text-align: center; border: none;">SUFFIX (2)</td> </tr> <tr> <td style="border: none;">④ _____</td> <td style="border: none;">⑤ _____</td> </tr> </table> | NUMBER (9) | SUFFIX (2) | ④ _____ | ⑤ _____ | DISCOUNT AMOUNT | DISCOUNT DATE | |
| NUMBER (9) | SUFFIX (2) | | | | | | |
| ④ _____ | ⑤ _____ | | | | | | |
| NAME (30) ⑥ _____ (30) _____ ADDR (30) ⑦ _____ (30) _____ (30) _____ | CLAIMANTS CERTIFICATION I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source. | | MO (2) DY (2) YR (2) | | | | |
| Claimants Name _____ X _____ By (Signature) _____ | | Date _____ Title _____ | | | | | |
| DEPT. GOODS OR SERVICES DELIVERED TO | | VENDOR'S PAYMENT TERMS | | | | | |
| ⑨ _____ | | ⑩ _____ | | | | | |

| ⑪ DATE DELIVERED | ITEMIZATION | UNIT PRICE | AMOUNT |
|-------------------|-------------|------------|--------|
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| ⑫ TOTAL CLAIMED ▶ | | | |

For Nassau County Department Use Only:
 NIFS ACCOUNT CODES *Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.*

| LINE # | INDEX | SUBOBJ | USERCODE | PROJECT | PROJIDDETAIL | GRANT | GRTDETAIL | G/L ACCOUNT | SUBSIDIARY | AMOUNT |
|---|-------|--------|----------|---------|--------------|-------|-----------|-------------|------------|--------|
| 1 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "Invoice no. or claim no." description | | | | | | | | | | |
| 2 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "Invoice no. or claim no." description | | | | | | | | | | |
| 3 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "Invoice no. or claim no." description | | | | | | | | | | |
| 4 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "Invoice no. or claim no." description | | | | | | | | | | |

| | |
|--|---|
| NC Department _____ Contact Person _____ Telephone No. _____ | Amount Approved \$ _____ Date _____ Comptrollers Approval _____ |
|--|---|

| | | | | | |
|--------------------------------------|--|---------------|--|---|--|
| INVOICE NUMBER | | | DOCUMENT # _____ <i>(FOR NASSAU COUNTY DEPARTMENT USE ONLY)</i> | | |
| ① _____ | | | _____ | | |
| ORDER / CONTRACT NO. | | | BLANKET ORDER NO. | | |
| ② _____ | | | ③ _____ | | |
| VENDOR INFORMATION: | | NUMBER (9) | SUFFIX (2) | DISCOUNT AMOUNT | |
| ④ _____ | | ⑤ _____ | | DISCOUNT DATE | |
| NAME (30) | | | | <p style="text-align: center; color: red;">CLAIMANTS CERTIFICATION</p> <p>I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source.</p> | |
| ⑥ _____ | | | | | |
| ADDR (30) | | | | | |
| ⑦ _____ | | | | | |
| ⑧ _____ | | | | Claimants Name _____ Date _____ X _____ Title _____ By (Signature) _____ | |
| DEPT. GOODS OR SERVICES DELIVERED TO | | | | ⑩ VENDOR'S PAYMENT TERMS | |
| ⑨ _____ | | | | _____ | |

| ⑪ DATE DELIVERED | ITEMIZATION | UNIT PRICE | AMOUNT |
|-------------------|-------------|------------|--------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| ⑫ TOTAL CLAIMED ▶ | | | |

For Nassau County Department Use Only: Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.

| LINE # | INDEX | SUBOBJ | USERCODE | PROJECT | PROJDETAIL | GRANT | GRTDETAIL | GL ACCOUNT | SUBSIDIARY | AMOUNT |
|---|-------|--------|----------|---------|------------|-------|-----------|------------|------------|--------|
| 1 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "invoice no. or claim no." description | | | | | | | | | | |
| 2 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "invoice no. or claim no." description | | | | | | | | | | |
| 3 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "invoice no. or claim no." description | | | | | | | | | | |
| 4 | | | | | | | | | | |
| INVOICE NO or CLAIM NO and DESCRIPTION (50): _____ FORMAT - "invoice no. or claim no." description | | | | | | | | | | |

| | |
|----------------------|-----------------------------|
| NC Department _____ | Amount Approved \$ _____ |
| Contact Person _____ | Date _____ |
| Telephone No. _____ | Comptrollers Approval _____ |

NASSAU COUNTY REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION



| | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> New Vendor | OR | <u>Change of Existing (Check All That Apply)</u> | | |
| <input type="checkbox"/> Name Change | <input type="checkbox"/> Add/Change Electronic Remittance Information | <input type="checkbox"/> Contact Change | | |
| <input type="checkbox"/> Address Change | <input type="checkbox"/> Add/Change Check Remittance Information | <input type="checkbox"/> OTHER Change | | |

Section I – Vendor Information (*required)

| | | | | | | | | | | | |
|---|---|--|--|--|--|--|--|--|--|--|--|
| 1. Federal ID No or Social Security No. | <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | | |
| 2. Vendor Name: | | | | | | | | | | | |
| 3. Vendor Remittance Address: | | | | | | | | | | | |
| 4. Vendor Contact Person: | | | | | | | | | | | |
| 5. Vendor Contact Telephone No.: | | | | | | | | | | | |
| 6. Vendor E-Mail Address: | | | | | | | | | | | |
| 7. Please answer the questions below. | | | | | | | | | | | |
| A. The vendor/payee ID number provided above is: Federal ID# [] Social Security # [] | C. Is a medical or legal service ever provided by vendor: Yes [] No [] | | | | | | | | | | |
| B. Is vendor/payee incorporated: Yes [] No [] | D. Is vendor/payee an employee of Nassau County: Yes [] No [] | | | | | | | | | | |
| | E. Parent of Child in Early Intervention or Pre-School Special Education Program Yes [] No [] | | | | | | | | | | |

Section II -Financial Institution Information-Complete this section only if you would like to be paid electronically.

| | | | | | | | | | | | |
|--|---|--|--|--|--|--|--|--|--|--|--|
| 8a. Routing Transit Number: <i>(Located at the bottom of your check)</i> | <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | | |
| 8b. Routing Transit Number Being Replaced (if applicable): | <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | | |
| 9a. Bank Account Number: | <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | | |
| 9b. Bank Account Number Being Replaced (if applicable): | <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | | |
| 10. Account Name: | | | | | | | | | | | |
| 11. Bank Name: (8a.) | | | | | | | | | | | |
| (8b.) | | | | | | | | | | | |
| 12. Please include a VOIDED check or Bank Letter for verification. | | | | | | | | | | | |

Check here [] if you wish to be removed from electronic payments and would like to receive paper checks.

14. Vendor Certification: Certification-Under penalties of perjury, I certify that: (1) The number shown on this form is my correct identification number (or I am waiting for a number to be issued to me), and (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends or (c) the IRS has notified me that I am no longer subject to backup withholding. (3) The information provided on this form is correct to the best of my knowledge. **Certification Instructions-**You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on you tax return. For real estate transactions, item (2) does not apply. The IRS does not require your consent to any provision of this document other than the certification required to avoid backup withholding. I understand that if I have completed Section II that I authorize payments to be received by electronic funds transfer into the bank account designated in Section II. I further understand that in the event that an erroneous electronic payment is sent, Nassau County reserves the right to reverse the electronic payment, In the event that a reversal cannot be implemented, Nassau County will utilize any other lawful means to retrieve payments to which the payee was not entitled.

| | | |
|----------------------|------------------|------|
| Authorized Signature | Print Name/Title | Date |
|----------------------|------------------|------|

[Dept. Use] Form Submitted By: (Name) _____
 (NC Department) _____ (Contact #) _____
 Office use only; disburse type 2 account type C
 Nassau County Comptroller's Office