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:______________________
ADDRESS: __________________________
____

CLAIM PERIOD: Sep – Dec

DATE OF BIRTH: ______________________
SERVICE PROVIDER: ___________________
SERVICE LOCATION: ___________________
____
SCHOOL YEAR: _______________________

CHILD IS:
☐ Early Intervention (Birth to 2yrs & 11 mos.)
EI Auth. #: __________________________
☐Preschool Age (3 – 5 years)
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 ____________ X ____________ X 2= $____________
One-Way Mileage # of Days 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:_____

JAN FOR PARENT/GUARDIAN USE ONLY	FEB FOR PARENT/GUARDIAN USE ONLY	MAR 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
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 Verified by:_____ SCHOOL REPRESENTATIVE DATE _____ SCHOOL REPRESENTATIVE TITLE (PRINT)	**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 Verified by:_____ SCHOOL REPRESENTATIVE DATE _____ SCHOOL REPRESENTATIVE TITLE (PRINT)	**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 Verified by:_____ SCHOOL REPRESENTATIVE DATE _____ SCHOOL REPRESENTATIVE TITLE (PRINT)

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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 _____ X _____ X 2= $_____

One-Way Mileage | # of Days | Reimbursement Rate

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

CHILD'S NAME:_____
ADDRESS: _____
_____

CLAIM PERIOD: Apr – June

DATE OF BIRTH: _____
SERVICE PROVIDER: _____
SERVICE LOCATION: _____
_____

SCHOOL YEAR: _____

CHILD IS:
☐ Early Intervention (Birth to 2yrs & 11 mos.)
EI Auth. #: _____
☐Preschool Age (3 – 5 years)
NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM:_____

APR FOR PARENT/GUARDIAN USE ONLY	**MAY FOR PARENT/GUARDIAN USE ONLY**	**JUNE 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
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 Verified by:_____ **SCHOOL REPRESENTATIVE DATE** _____ **SCHOOL REPRESENTATIVE TITLE (PRINT)**	**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 Verified by:_____ **SCHOOL REPRESENTATIVE DATE** _____ **SCHOOL REPRESENTATIVE TITLE (PRINT)**	**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 Verified by:_____ **SCHOOL REPRESENTATIVE DATE** _____ **SCHOOL REPRESENTATIVE TITLE (PRINT)**

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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 _____ X _____ X 2= $_____
One-Way Mileage | # of Days | 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: July – Aug SCHOOL YEAR: _____ NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM:_____

JULY FOR PARENT/GUARDIAN USE ONLY	**AUG 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
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 Verified by:_____ **SCHOOL REPRESENTATIVE DATE** _____ **SCHOOL REPRESENTATIVE TITLE (PRINT)**	**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 Verified by:_____ **SCHOOL REPRESENTATIVE DATE** _____ **SCHOOL REPRESENTATIVE TITLE (PRINT)**

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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 _____ X _____ X 2= $_____

One-Way Mileage | # of Days | Reimbursement Rate

COUNTY OF NASSAU

CLAIM VOUCHER

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

① INVOICE NUMBER

DOCUMENT # (FOR NASSAU COUNTY DEPARTMENT USE ONLY)

② ORDER /CONTRACT NO.

③ BLANKET ORDER NO.

VENDOR INFORMATION: NUMBER (9) SUFFIX (2)

④ ⑤

⑥ NAME (30)

(30)

⑦ ADDR (30)

(30)

(30)

DISCOUNT AMOUNT

DISCOUNT DATE MO (2) DY (2) YR (2)

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.

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
		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	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
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 _____

COUNTY OF NASSAU

CLAIM VOUCHER

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

① INVOICE NUMBER

DOCUMENT # (FOR NASSAU COUNTY DEPARTMENT USE ONLY)

② ORDER /CONTRACT NO.

③ BLANKET ORDER NO.

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By (Signature) — Title

⑨ DEPT. GOODS OR SERVICES DELIVERED TO

⑩ VENDOR'S PAYMENT TERMS

⑪ DATE DELIVERED	ITEMIZATION	UNIT PRICE	AMOUNT
		⑫ TOTAL CLAIMED ▶	

For Nassau County Department Use Only:

NIFS ACCOUNT CODES

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LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

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FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
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 _____

FORM NIFS560.11/98 NCPG

COMPTROLLER COPY

CO-155-A.3/98 REV. 10/00

COUNTY OF NASSAU

CLAIM VOUCHER

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

① INVOICE NUMBER

DOCUMENT #

(FOR NASSAU COUNTY DEPARTMENT USE ONLY)

② ORDER /CONTRACT NO.

③ BLANKET ORDER NO.

VENDOR INFORMATION: NUMBER (9) SUFFIX (2)

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(30)

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DISCOUNT AMOUNT

DISCOUNT DATE MO (2) DY (2) YR (2)

CLAIMANTS CERTIFICATION

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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
		⑫ TOTAL CLAIMED ▶	

For Nassau County Department Use Only:

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LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

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LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
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 _____

COUNTY OF NASSAU

CLAIM VOUCHER

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

① INVOICE NUMBER

DOCUMENT # |_|_|_|_|_|_|_|_|_|_|_|_|_|_|

(FOR NASSAU COUNTY DEPARTMENT USE ONLY)

② ORDER /CONTRACT NO. |_|_|_|_|_|_|_|_|_|_|_|_|_|_|

③ BLANKET ORDER NO. |_|_|_|_|_|_|_|_|_|_|_|_|_|_|

VENDOR INFORMATION: NUMBER (9) SUFFIX (2)

④ _____ ⑤ _____

⑥ NAME (30) _____

(30) _____

⑦ ADDR (30) _____

(30) _____

(30) _____

DISCOUNT AMOUNT _____

DISCOUNT DATE MO (2) DY (2) YR (2)

CLAIMANTS CERTIFICATION

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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
		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	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
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

☐ New Vendor OR Change of Existing (Check All That Apply)

☐ Name Change ☐ Add/Change Electronic Remittance Information ☐ Contact Change

☐ Address Change ☐ Add/Change Check Remittance Information ☐ OTHER Change

Section I – Vendor Information (*required)

1. Federal ID No or Social Security No.

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 # [ ]

B. Is vendor/payee incorporated: Yes [ ] No [ ]

C. Is a medical or legal service ever provided by vendor: 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: *(Located at the bottom of your check)*

8b. Routing Transit Number Being Replaced (if applicable):

9a. Bank Account Number:

9b. Bank Account Number Being Replaced (if applicable):

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