Attachement B2

Rensselaer County
Department of Social Services
Vendor Claim

Remit to: Accounting Unit
127 Bloomingrove Dr
Troy, NY 12180

Month of Service: _____

Provider's Name:_____ Vendor ID: _____

Address:_____ Phone: _____

*** Indicate Billing Rate Type (i.e. Mo, Wk, Day, PT, Hr)**

Case #	Parent Name	Child Name	# days/ hours billed	# Abs	***Billing Rate Type**	Rate

Vendor Certification

I, _____Do Hereby CERTIFY that I am the _____ of

the _____.

That the items of the above account are correct; that the disbursements and services Charged herein have in fact been made and rendered to or for the County of Rensselaer And that no part thereof has been paid or satisfied; that taxes from which the county of Rensselaer is exempt, are not included; and that the amount claimed is actually due; and there has been Compliance with the Title VI of the Federal Civil Rights Act of 1964 as amended and Section 504 Of the Rehabilitation Act of 1973 and regulations contained in 45 CFR Part 84 without Discrimination on the basis of race, color, religion, sex, national origin, or handicap.

SIGNATURE _____ DATE _____