LDSS-3546 (5/99)

Attachment #8

ORDER FOR SUPPLIES/SERVICES (VOUCHER)

VENDOR-RETURN TO DISTRICT

ONONDAGA
COUNTY DEPARTMENT OF SOCIAL SERVICES

NO.

421 MONTGOMERY ST. 4TH FLOOR ACCOUNTING. SYRACUSE. NY 13202

NON SERVICES X FOSTER CARE SERVICES

SIGNATURE OF RECIPIENT, IF REQUIRED	AUTHORIZED BY	DATE
VOID	VOID	

DATE OF ISSUE
VENDOR ID
SERVICE/PAYMENT TYPE

VENDOR NAME AND ADDRESS

COUNTY USE ONLY

I HEREBY CERTIFY, that the merchandise, materials, or articles enumerated in the above account have been received, and the services specified performed; that they were necessary for and have been, or will be to the use of the above department or its recipient(s).

SIGNATURE TITLE DATE

AUDITED BY INITALS	CHECK NUMBER	CHECK DATE

CASE NUMBER	AUTHORIZATION NUMBER	DESCRIPTION OF SUPPLIES OR SERVICES and/or RECIPIENT NAME, ADDRESS, ACCOUNT NUMBER, CIN AND SERVICE PERIOD/DATE OF DELIVERY	AMOUNT	
			AUTHORIZED	CLAIMED
		VOID		
		VOID		
		VOID		

TOTAL AMOUNT CLAIMED CANNOT EXCEED AMOUNT AUTHORIZED

NUMBER OF PAYMENTS DATE DUE

Pursuant to the provisions of Section 369 of the County Law of the State of New York, I do hereby certify that the labor or services, merchandise, materials or articles charged in the within account or claim, amounting to $_____ have been actually performed, made or delivered for the COUNTY OF or for the County on behalf of a recipient(s); that the items and specifications therein are correct; that the prices charged therefor are reasonable and just; that no perquisites, commissions or allowances of any kind, other than as stated in the said account, have been or will be paid directly or indirectly, in consideration of the procurement of said articles or services; and that the said item or items contained in this bill or claim have not been, either in whole or any part, paid or satisfied and that the full amount is now justly due and that no part thereof has heretofore been presented for audit or payment.

CLAIMANT SIGNATURE _____ DATE _____

Vendor, see other side for instructions for completion of this form.