The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Massachusetts Commission for the Deaf and Hard of Hearing

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CART Invoice Form for MCDHH Paid Assignment

INSTRUCTION TO VENDORS – Please fill in *ALL and ONLY* the shaded areas

PRC DOCUMENT CODE

CT REFERENCE ENCUMBRANCE DOC

HEADER INFORMATION

Fiscal Year	
Period	
Doc Total	

For MCDHH use only

VENDOR INFORMATION

Vendor/Customer ID (10 digits VC number) VC ____ ____ ____ ____ ____ ____ ____ ____ ____ ____		
Vendor Name		
Vendor Address		
City	State	Zip

LINE-COMMODITY INFORMATION

Date of Service	Time of Service From _____ AM / PM to _____ AM / PM			
Quantity	**Unit of Measure**	**Description**	**Unit Rate**	**Amount**
	Hours			
	Mileage			
	Travel Time	_____ Miles **÷ 50 =** _____ **X** _____ ½ of Hour Rate **=**		
	Projection			
	Equipment Fee			
	Other			
		Grand Total		

VENDOR CERTIFICATION

Consumer Signature – by my signature, I certify that I received service as set forth above
Vendor Signature – by my signature, I certify that I rendered services as set forth above

Vendor Invoice #	Vendor Invoice Date

LINE-ACCOUNTING INFORMATION

Commodity Line #	Service from Date (mm/dd/yyyy)	Service to Date (mm/dd/yyyy)

Event Type	Line Description	Subtotal Line Amt	Ref Acct Line	P / F	Fund	Sub Fund
AP01						

Department	Unit	Appropriation	Object	Program	Program Period
MCD	**0001**				

To the Comptroller of the Commonwealth of Massachusetts – I hereby certify under penalties of perjury that all laws of the Commonwealth governing disbursement of public funds and the regulation thereof have been complied with.

Prepared by	Title	**Accountant**	Date
MMARS Entry by	Title	**Clerk IV**	Date
Submitted by	Title	**Business Manager**	Date
Authorized Signature	Title	**CFO**	Date