VENDOR INVOICE FOR GOODS OR SERVICES RENDERED TO THE STATE OF CONNECTICUT
CO - 17 REV. 10/2010

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
ACCOUNTS PAYABLE DIVISION

VENDOR: PLEASE COMPLETE THIS FORM AND SEND IT TO THE DEPARTMENT **BILLING ADDRESS** SHOWN ON THE PURCHASE ORDER

(1) BUSINESS UNIT NAME	(2) BUSINESS UNIT NO.	(3) INVOICE NO.	(4) INVOICE AMOUNT
ADS/LTCOP			

(5) DOCUMENT DATE	(6) INVOICE DATE	(7) ACCOUNTING DATE	(8) RPT. TYPE	(9) VENDOR FEIN/SSN ID / ADDRESS CODE

VENDOR / PAYEE: FIELDS 9,10,14 and 18 ARE MANDATORY FOR PAYMENT

(10)
PAYEE:
PAYEE:
ADDRESS:
ADDRESS:
ADDRESS:
CITY: TOWN STATE : CT COUNTRY: US ZIP CODE : ZIP

(11) VOUCHER NO.

(12) VOUCHER DATE

PREPARED BY

(13) VENDOR COMMENTS

(14) GIVE FULL DESCRIPTION OF GOODS AND / OR SERVICES (TO BE COMPLETED BY VENDOR)	(15) QUANTITY	(16) UNITS	(17) UNIT PRICE	(18) AMOUNT
			.70	
VRA Signature: __VRA SIGNATURE | DATE_____				
RO Signature: _____			TOTAL	

BUSINESS UNIT USE ONLY

(19) AMOUNT	(20) QUANTITY	(21) FUND	(22) DEPARTMENT	(23) SID	(24) PROGRAM	(25) ACCOUNT	(26) PROJECT/ GRANT	(27) CHARTFIELD 1	(28) CHARTFIELD 2	(29) BUDGET REFERENCE
		12060	63911	20835	52992	50800	30101	191010	-----	2024

(30) DEPARTMENT NAME AND ADDRESS
Department on Aging and Disability Services
55 Farmington Ave, 12th Floor
Hartford, CT 06105

(31) PO NO.

(32) COMMODITIES RECEIVED OR SERVICES RENDERED - SIGNATURE

(33) PO BUSINESS UNIT

(34) RECEIVING REPORT NO.

(35) DATE(S) OF RECEIPT(S)

SHIPPING INFORMATION

(36) DATE SHIPPED	(37) FROM - CITY / STATE	(38) VIA - CARRIER	(39) F.O.B.