State of Illinois
Department of Human Services

Request for Expedited Payments

Agency/Vendor Name: _____

Agency FEIN: _____ Agency Phone Number: _____

Legal Status:

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ Corporation
- ☐ Not-For-Profit
- ☐ Governmental Unit

Address: _____

City: _____ State: _____ Zip (nine digit) _____

Date of Request: _____

Type of Request: ☐ One Time for Prior Approved Payments ☐ Multiple Occurrences for Future Payments

Type of Services Provided:

Reason for expedite payments (please use additional pages if necessary)

Total number of clients served _____

Number of DHS clients served _____

Percentage of clients served that are DHS clients _____ %

Total agency revenue for last fiscal year _____

Agency revenue attributed to DHS clients _____

Percentage of Revenue attributed to DHS clients served _____ %

State of Illinois
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Request for Expedited Payments

Requested number of months expedited payments are required _____

Additional Information Attached

- ☐ Current Financial Statement
- ☐ Copy of letter from Financial Institution denying additional credit
- ☐ Documentation of Bankruptcy filing

Requested By:

_____
Name

_____ _____
Signature Date of Signature

_____
Title

Board of Directors (if required):

_____
Name

_____ _____
Signature Date of Signature

_____
Title

Vendor/Contact email address: _____

FOR DHS STAFF USE ONLY

Date request received: _____

☐ Request Approval ☐ Request Denied Effective Date: _____

Are Services Medicaid Eligible ☐ Yes ☐ No

Are Services Eligible for Prompt Payment Interest ☐ Yes ☐ No

Reason for Denial:

Signature of Local Administrator: _____ Date: _____

(Network Mrg, Fac. Director, etc.)

Approved by:

Division/Administrative Office: _____ Date: _____

Office of Fiscal Services: _____ Date: _____

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