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

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VP (617) 326-7546
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http://www.mass.gov/mcdhh

INTERPRETER INVOICE FORM FOR PAID ASSIGNMENT

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

PRC DOCUMENT CODE	CT REFERENCE	APPROPRIATION

VENDOR INFORMATION

VENDOR CODE		**NAME**			**INVOICE #**		
ADDRESS		**CITY**		**STATE**		**ZIP CODE**	
REQUEST #		**ASSIGNMENT #**		**DOCKET #**			

For Court only

LINE-COMMODITY INFORMATION

DATE OF SERVICE	START TIME	END TIME	FOR (Business Name)

QUANTITY	RATE/FEE	DESCRIPTION							AMOUNT
		HOURS: ☐ ASL ☐ Low-Vision ☐ Deaf-Blind ☐ Legal ☐ No Meal							$ 0.00
	$ 5.00	ONSITE:							0.00
	$ 0.62	TRAVEL: ☑ Mileage ☐ Public Transportation Minimum 20 miles for one-way or 40 miles for round trip							0.00
		TRAVEL TIME	0 Miles	÷ 50 =	0	x	0 1/2 Hour Rate	=	0.00
									0.00
									0.00
									0.00
								TOTAL	$ 0.00

Vendor Signature - By my signature, I certify that I received service as set forth above	**Date**

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

Prepared/MMARS Entry by:		**Title:**	Accountant	**Date:**	
Submitted by:		**Title:**	Business Manager	**Date:**	
Authorized Signature:		**Title:**	CFO	**Date:**	