

100000000000060610701MCDMCDH08141900000140000000014000VC60001921389

INVOICE

Remit to:

PAY ONLINE AT MASSPAYS.COM/MCD
MASS. COMMISSION FOR THE DEAF
AND HARD OF HEARING
600 Washington St
Boston MA 02111

Bill to:

CITY OF SOMERVILLE
165 BROADWAY
SOMERVILLE MA 02145-2102

Customer Name

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CITY OF SOMERVILLE

Customer Number	Invoice Number	Notice Date
VC6000192138	DM190523191524900000	06-22-19
E-Payment ID	AR Dept BPRO	Due Date
0060610701	MCD:MCDH	08-14-19
	Amount Due	Amount Enclosed
	\$140.00	

Payment Method: Check ☐ Money Order ☐

☐ Please check if address has changed. Write correct address on back of stub and attach with payment

Please write Invoice No on front of check or Money Order. DO NOT MAIL CASH

Please detach the above stub and return with your remittance payable to COMMONWEALTH OF MASS OR ONLINE AT MASSPAYS.COM/M



Commonwealth of Massachusetts
COMMISSION FOR THE DEAF AND HARD OF HEARING
ORIGINAL

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			Customer Number VC6000192138			
Customer Name CITY OF SOMERVILLE		Invoice Number DM190523191524900000	Notice Date 06-22-19	Due Date 08-14-19		
Invoice Charges						
Ref Line No.	DESCRIPTION	Invoice Date	No.of Units	Unit of Measure	Unit Price	Charges/ Credit
1	SIGN LANGUAGE INTERPRETATION SERVICE 5/23/19	05-23-19				\$140.00
Credit Payments Applied						
Total Amount Due By 08-14-19						\$0.00
						\$140.00

Instructions

****NEW, OUR PAYMENT SITE HAS CHANGED**** VIEW AND PAY ALL CURRENT AND PAST DUE MCD INVOICES ONLINE AT MASSPAYS.COM/MCD

Please check this bill for accuracy. If you have recently made a payment it will be reflected in your next bill. Questions? Please call the Contact listed below. HEARING ADDRESS: IF THIS IS A PAST DUE NOTICE (AND NOT AN INITIAL INVOICE) YOU MAY MAIL A WRITTEN REQUEST FOR A HEARING TO: MASS COMMISSION FOR THE DEAF AND HARD OF HEARING 150 MT VERNON STREET - SUITE 550 BOSTON, MA 02125

CONTACT: COMMISSION FOR THE DEAF AND HA

617-740-1600

Massachusetts Commission for the Deaf and Hard of Hearing

Staff Interpreter Billing Form

Staff Interpreter Name: <i>D. Martinez</i>	Requester Name: <i>Nancy Salamon</i>
Billing Contact Name: <i>Nancy Salamon</i>	Requester Phone Number: <i>617-625-6600</i>
Company Name: <i>City of Somerville</i>	Appointment Address/Department: <i>220 Washington St Somerville, MA Somerville Police Family Service Unit</i>
Billing Address: <i>165 Broadway SV MA 02145</i>	

Assignment #	Service Date	Start Time	End Time
1524900	5/23/19	10-12	

Quantity	Item	Description	Unit Price	Total
2	Hour(s) (2 hrs minimum)	Sign Language Interpretation Service	70	140
	Mileage	Odometer reading: _____ to _____		
	Travel Time	*		
	Other Fee	<input type="checkbox"/> Parking <input type="checkbox"/> Tolls <input type="checkbox"/> Public Transportation		
*Travel time formula - (total miles ÷ 50 = _____ X 1/2 of hourly rate = travel reimbursement) Note: Must travel a minimum of 20 miles each way to be eligible for travel reimbursement			Total	140

An invoice payable to MCDHH will be issued shortly

I certify that the above information is true and correct. Information will be kept strictly confidential.

Staff Interpreter Signature - by my signature, I certify that the above information is true and correct

Signature of Verification - by my signature, I certify that the above information is true and correct
X

For MCDHH Use Only					Reference Number:
<input type="checkbox"/> Job was cancelled	Date of Cancellation:	Time of Cancellation:	By:		
Vendor/Customer ID: <i>VC0000192138 AD008</i>					
MMARS Document ID#:					
Fund 0300	Sub-Fund 2697	Revenue 3500	Department MCD	Unit 0001	
Description:					
Prepared By: <i>MAH</i>			Date: <i>6-19-19</i>		
Entered By:			Date: <i>6/25/19</i>		
Submitted/Approved By: <i>Edgout</i>			Date:		