ALABAMA BOARD OF ADJUSTMENT
VENDOR'S CLAIM FOR PAYMENT

Print Form

Instructions: **USE THIS FORM TO CLAIM PAYMENT FOR SERVICES OR GOODS PROVIDED TO AN AGENCY OF THE STATE OF ALABAMA. READ THE ENTIRE CLAIM FORM FOR DETAILED INSTRUCTIONS**.

THIS CLAIM MUST BE SIGNED AND THE INFORMATION THAT YOU PROVIDE VERIFIED AS TRUTHFUL UNDER OATH BEFORE A NOTARY PUBLIC.

THE DEADLINE FOR FILING A CLAIM:
A CLAIM MUST BE FILED WITH THE BOARD OF ADJUSTMENT WITHIN ONE YEAR OF THE DATE THAT THE ACCOUNT WAS DUE TO BE PAID ACCORDING TO THE TERMS OF THE TRANSACTION.

Give complete information and attach all requested documentation to prove your claim. The burden of proving that payment is due rests with the claimant. Failure to provide complete information with this claim may affect the decision of the Board.

DO NOT WRITE IN THIS SPACE
Claim No.: Supplement No.:

If a SUPPLEMENT to a previously filed claim, provide original Claim Number:_____

FILE THIS FORM AND ALL DOCUMENTS BY MAILING TO:
State Board of Adjustment
600 Dexter Avenue, Suite E-302
Montgomery, AL 36130-1435

OR DELIVER TO: State Board of Adjustment
State Capitol Building, Suite E-310
Montgomery, AL

Name of Department or Agency of the State of Alabama against which you are making this claim:

NOTICE: ALL COMMUNICATIONS WITH THE CLAIMANT REGARDING THIS CLAIM WILL BE BY FAX OR E-MAIL TO THE FAX NUMBER OR E-MAIL ADDRESS SHOWN IN ITEM A.1. UNLESS THIS BOX IS MARKED ☐. AFTER FILING THIS ORIGINAL CLAIM FORM, SIGNED AND NOTARIZED WITH SUPPORTING DOCUMENTATION, CLAIMANT MAY COMMUNICATE WITH THE BOARD OF ADJUSTMENT BY E-MAIL AT BDADJ@FINANCE.ALABAMA.GOV. THE CLAIM NUMBER MUST BE STATED IN THE SUBJECT LINE.

A. Claimant Information:

1. Name and Mailing Address of Claimant for communications regarding this claim:

Claimant:

To Attention of:

Mailing Address:

(Street or Post Office Box) (City) (State) (Zip Code)

Social Security No. for individual claimant or Federal ID No. for Business Claimant:

Telephone Number: Fax Number:

E-mail Address:

2. Claimant's Attorney (***If an attorney is representing claimant on this claim, all correspondence and communication will be with that attorney***):

Name:

Mailing Address:

(Street or Post Office Box) (City) (State) (Zip Code)

Telephone Number: Fax Number:

E-mail Address:

B. Facts of claim:

1. Date account was due to be paid according to payment terms:
2. Last date Service provided or goods were delivered:
3. Statement of Facts: Describe goods or services sold, terms of payment, the agency's reason for not paying this debt. Attach a copy of purchase orders, contracts, work orders, all communications with the Agency regarding payment, and other documentation that relate to the claim and non-payment by the Agency.

Claimant Name

C. TOTAL AMOUNT CLAIMED:

(Documentation demonstrating how this amount was calculated must be attached.)

1. The undersigned represents that no part of this claim has been assigned to another entity and no amount has been paid on behalf of the claimant or received in payment of this claim for any amount except as set out as follows:

Signature of claimant/authorized representative:

Must bear original signature (not a machine copy) of claimant or his/her representative.

Print name

VERIFICATION

STATE OF }

COUNTY OF }

Before me, a Notary Public in and for said state and county, personally appeared the person whose name is signed above who being made known to me and being duly sworn to give true testimony, affirmed that all of the above stated facts are true and correct.

Sworn and subscribed before me this day of ,20

Signature of Notary Public

AFFIX SEAL

Printed Name