

West Virginia Legislative Claims Commission
Telephone (304) 347-4851
Fax (304) 347-4915

Instructions for Filing a **VENDOR** Claim

COMPLETE COMPANY or CORPORATE NAME: Name of vendor.

RESPONDENT: Name of the State agency which incurred the expense.

AMOUNT OF CLAIM: **Accurate** total of the invoices.

CONTACT PERSON AND/OR ATTORNEY INFORMATION: Name, mailing address and e-mail address of the individual (the contact person) who is responsible for maintaining the information about the claim on behalf of the vendor. If the claim is contested, the vendor corporation **shall be** represented by an attorney.

FISCAL YEAR: Vendors should denote the fiscal year(s) for the invoices which constitute the claim. The State fiscal year runs from July 1 through June 30.

FACILITY: List the facility within the State agency which incurred the expense. For example: the Division of Corrections (the State agency) has numerous facilities, such as Mt. Olive Correctional Center, Huttonsville Correctional Center, etc.

REASON(S) FOR NONPAYMENT: Briefly state whether the invoices are for merchandise or services. Include description of services rendered and/or merchandise delivered.

SIGNATURE: Claim form **MUST** be signed by an individual with the legal capacity to bring a lawsuit on behalf of the company, corporation, or partnership.

DISTRIBUTION OF COPIES:

1. Submit white copy of claim form to this office and keep yellow copy for your records.

FAILURE TO COMPLY WITH THESE INSTRUCTIONS MAY DELAY THE PROCESSING OF YOUR CLAIM.

Please read instructions thoroughly before completing this form.

West Virginia Legislative Claims Commission
 1900 Kanawha Blvd., E., Room W-334
 Charleston, WV 25305-0610
 (304) 347-4851 or (877) 562-6878 (toll free)
 www.legis.state.wv.us/joint/claimscommission.cfm
 Email: legis.claims.commission@wvlegislature.gov

OFFICE USE ONLY
 CC- _____

Suggested Form of Notice of VENDOR Claim

This claim form and any accompanying exhibits may be submitted via e-mail. Please type or print.

Complete Name of Company or Corporation _____

VS.

Respondent State Agency _____

Amount Claimed : \$ _____

Was the respondent State agency informed of the claim? Yes No

<u>Vendor's Contact Person Information</u>	<u>Attorney Information</u> (if attorney represents you in this claim)
Name of Contact Person _____	Name _____
E-mail (please print clearly) _____	E-mail (please print clearly) _____
Mailing Address _____	Mailing Address _____
City _____	City _____
County _____	County _____
State _____ Zip _____	State _____ Zip _____
Telephone Number _____	Telephone Number _____
Fax Number _____	Fax Number _____

Fiscal Year(s) (July 1 - June 30) in which expense was incurred: FY- _____

Facility or Facilities Incurring Expense (if applicable) _____
 (examples: Mt. Olive, Southern Regional Jail, etc.)

Notice of Vendor Claim

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REASON(S) FOR NONPAYMENT AND DESCRIPTION OF SERVICES RENDERED:

Print or type name of person signing below

Signature of authorized person or designated attorney

 **MUST BE SIGNED**

Date of signature

Upon the filing of this claim, you will receive an acknowledgment with an assigned claim number (example: CC-00-####). **Please refer to the assigned claim number in all correspondence with this office.**

§14-2-26: "A person who knowingly and wilfully presents or attempts to present a false or fraudulent claim, or a state officer or employee who knowingly and wilfully participates or assists in the preparation or presentation of a false or fraudulent claim, shall be guilty of a misdemeanor..."