

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
CENTRAL ACCOUNTS PAYABLE DIVISION
165 CAPITOL AVENUE
HARTFORD, CT 06106



CO-790S Rev. 08/2021

1. BUSINESS UNIT		2. AGENCY NAME			3. STREET ADDRESS			4. CITY, STATE, ZIP		
5. SUPPLIER ID		6. SUPPLIER SHORT NAME		7. PAYEE NAME			8. PMT REFERENCE NO.		9. PAYMENT AMOUNT	10. PAYMENT DATE
11A. VOUCHER ID	12A. VOUCHER AMOUNT	11B. VOUCHER ID	12B. VOUCHER AMOUNT	11C. VOUCHER ID	12C. VOUCHER AMOUNT	11D. VOUCHER ID	12D. VOUCHER AMOUNT			

IF THIS FORM IS BEING COMPLETED BECAUSE OF A DUPLICATE PAYMENT, PROVIDE THE VOUCHER ID(S) AND PAYMENT REFERENCE NUMBER OF THE DUPLICATED PAYMENT

13A. VOUCHER ID	14A. VOUCHER AMOUNT	13B. VOUCHER ID	14B. VOUCHER AMOUNT	13C. VOUCHER ID	14C. VOUCHER AMOUNT	15. PMT REFERENCE NO.	16. PAYMENT AMOUNT		
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17. HAVE YOU ESTABLISHED PROCEDURES TO ELIMINATE INCORRECT PAYMENTS, OVERPAYMENTS, DUPLICATE PAYMENTS? YES NO

18. WILL YOU REQUIRE ASSISTANCE IN ESTABLISHING PROCEDURES FOR EFFECTIVE INTERNAL CONTROLS? IF YOU ANSWERED "YES", AN OSC REPRESENTATIVE WILL GET IN TOUCH WITH THE CONTACT PERSON LISTED BELOW. YES NO

SECTION A: PLEASE EXPLAIN THE PROCEDURES THAT LED TO THE ISSUANCE OF THE INCORRECT PAYMENT. PLEASE PROVIDE AN ANALYSIS, RATHER THAN A NARRATIVE.

SECTION B: DESCRIBE IN DETAIL THE INTERNAL ACCOUNTING CONTROLS IN PLACE, PRIOR TO THIS INCIDENT, FOR THIS TYPE OF TRANSACTIONS.

SECTION C: DESCRIBE IN DETAIL ANY REVISION TO EXISTING CONTROLS AND/OR IMPLEMENTATION OF NEW CONTROLS TO PRECLUDE A RECURRENCE OF SUCH INCIDENTS.

NAME OF CONTACT PERSON		TITLE		E-MAIL ADDRESS		TELEPHONE NUMBER	
AUTHORIZED SIGNATURE			NAME OF AUTHORIZED SIGNATOR		TITLE		DATE

PURPOSE OF THIS FORM:

This form must be used to explain overpayments, duplicate payments, incorrect payment amounts or any other type of improper payment that has transpired. Agency internal controls must be thoroughly reviewed and revised if necessary to prevent improper payments from recurring.

GENERAL INSTRUCTIONS

1. Complete Sections A, B, and C, above, in detail.
2. The completed form must be signed by the **Agency Head** or **Deputy** only. The form will be rejected if this instruction is not followed.
3. Attach the properly signed, completed form to the CO-790 and submit the documents to the Central Accounts Payable Division, Office of the State Comptroller - osc.apdsp@ct.gov.
4. If a CO-790 is not needed, send the completed form to the Central Accounts Payable Division, Office of the State Comptroller, Attn: Special Processing - osc.apdsp@ct.gov.