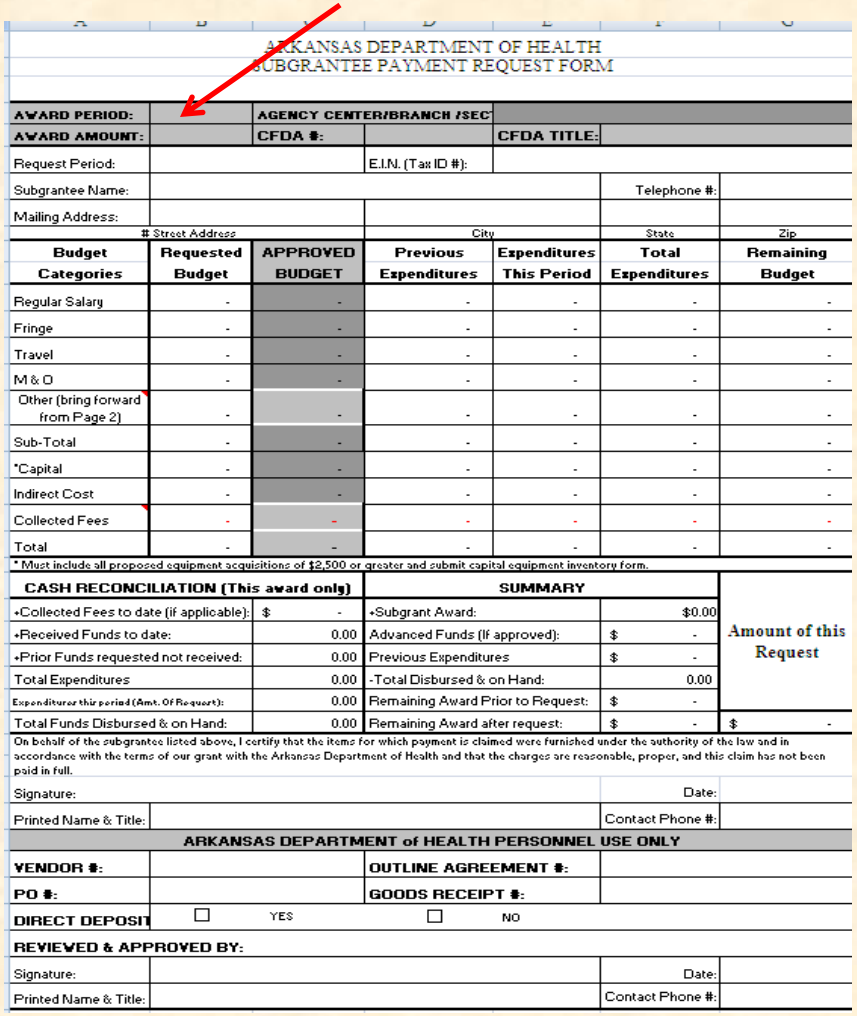
Reimbursement Request/Invoice

The award period should match the start and end dates on the purchase order

After the grant packet is reviewed a purchase order and fully executed copy of the grant will be sent to the grantee.

Following the receipt of the purchase order, the grantee can expend funds and send in request(s) for reimbursement on the state form.

The best practice is to spend all of the funding before sending in a request for reimbursement. If this is not possible the grantee can send in a request once per month.



ARKANSAS DEPARTMENT OF HEALTH
SUBGRANTEE PAYMENT REQUEST FORM

AWARD PERIOD:		AGENCY CENTER/BRANCH /SEC				
AWARD AMOUNT:		CFDA #:		CFDA TITLE:		
Request Period:			E.I.N. (Tax ID #):			
Subgrantee Name:					Telephone #:	
Mailing Address:						
	# Street Address		City		State	Zip

Budget Categories	Requested Budget	APPROVED BUDGET	Previous Expenditures	Expenditures This Period	Total Expenditures	Remaining Budget
Regular Salary	-	-	-	-	-	-
Fringe	-	-	-	-	-	-
Travel	-	-	-	-	-	-
M & O	-	-	-	-	-	-
Other (bring forward from Page 2)	-	-	-	-	-	-
Sub-Total	-	-	-	-	-	-
*Capital	-	-	-	-	-	-
Indirect Cost	-	-	-	-	-	-
Collected Fees	-	-	-	-	-	-
Total	-	-	-	-	-	-

* Must include all proposed equipment acquisitions of $2,500 or greater and submit capital equipment inventory form.

CASH RECONCILIATION (This award only)		SUMMARY		
+Collected Fees to date (if applicable):	$ -	+Subgrant Award:	$0.00	Amount of this Request
+Received Funds to date:	0.00	Advanced Funds (If approved):	$ -	
+Prior Funds requested not received:	0.00	Previous Expenditures	$ -	
Total Expenditures	0.00	-Total Disbursed & on Hand:	0.00	
Expenditures this period (Amt. Of Request):	0.00	Remaining Award Prior to Request:	$ -	
Total Funds Disbursed & on Hand:	0.00	Remaining Award after request:	$ -	$ -

On behalf of the subgrantee listed above, I certify that the items for which payment is claimed were furnished under the authority of the law and in accordance with the terms of our grant with the Arkansas Department of Health and that the charges are reasonable, proper, and this claim has not been paid in full.

Signature:		Date:	
Printed Name & Title:		Contact Phone #:	

ARKANSAS DEPARTMENT of HEALTH PERSONNEL USE ONLY

VENDOR #:		OUTLINE AGREEMENT #:	
PO #:		GOODS RECEIPT #:	
DIRECT DEPOSIT	☐ YES	☐ NO	
REVIEWED & APPROVED BY:			
Signature:		Date:	
Printed Name & Title:		Contact Phone #:	

Reimbursement Request/Invoice

Please enter the Award Amount in dollars and cents – For example: $12,740.00

The Request Period should be the start date on the purchase order till the date you send in the request

ARKANSAS DEPARTMENT OF HEALTH
SUBGRANTEE PAYMENT REQUEST FORM

AWARD PERIOD:		AGENCY CENTER/BRANCH /SECT			
AWARD AMOUNT:		CFDA #:		CFDA TITLE:	
Request Period:		E.I.N. (Tax ID #):			
Subgrantee Name:				Telephone #:	
Mailing Address:					
# Street Address		City		State	Zip

The Subgrantee Name should match the name in the state vendor (AASIS) system

Reimbursement Request/Invoice

The Requested Budget and the Approved Budget should match the amount listed in the purchase order and final grant copy budget

# Street Address			City		State	Zip
Budget Categories	**Requested Budget**	**APPROVED BUDGET**	**Previous Expenditures**	**Expenditures This Period**	**Total Expenditures**	**Remaining Budget**
Regular Salary	-	-	-	-	-	-
Fringe	-	-	-	-	-	-
Travel	-	-	-	-	-	-
M & O	-	-	-	-	-	-
Other (bring forward from Page 2)	-	-	-	-	-	-
Sub-Total	-	-	-	-	-	-
*Capital	-	-	-	-	-	-
Indirect Cost	-	-	-	-	-	-
Collected Fees	-	-	-	-	-	-
Total	-	-	-	-	-	-

* Must include all proposed equipment acquisitions of $2,500 or greater and submit capital equipment inventory form.

The Expenditures This Period can be for the total grant award or a portion of the grant award

If the grantee is only requesting a portion of the grant under Expenditures This Period, then there should be figures in the Remaining Budget column

Reimbursement Request/Invoice – Page 2

The second page of the Reimbursement Request/Invoice wasn't used during previous grant years. This page will be used now to list budget categories that are not listed on the first page.

The grantee should type in the Budget Category and then they will follow the same procedure of filling out the Requested Budget, Approved Budget and Expenditures This Period.

FIN-122 (R 3/10)

ARKANSAS DEPARTMENT of HEALTH PERSONNEL USE ONLY			
VENDOR #:		OUTLINE AGREEMENT #:	
PO #:		GOODS RECEIPT #:	
ABOVE IS FOR ARKANSAS DEPARTMENT of HEALTH PERSONNEL USE ONLY			

Budget Categories	Requested Budget	APPROVED BUDGET	Previous Expenditures	Expenditures This Period	Total Expenditures	Remaining Budget
	-			-	-	-
	-	-	-	-	-	-
	-	-	-	-	-	-
	-	-	-	-	-	-
	-	-	-	-	-	-
	-	-	-	-	-	-
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	-	-	-	-	-	-
	-	-	-	-	-	-
	-	-	-	-	-	-
	-	-	-	-	-	-
	-	-	-	-	-	-
Total	-	-	-	-	-	-

Reimbursement Request/Invoice

The total of the amounts on page two of the form should be entered in the "Other" category on the first page of the form.

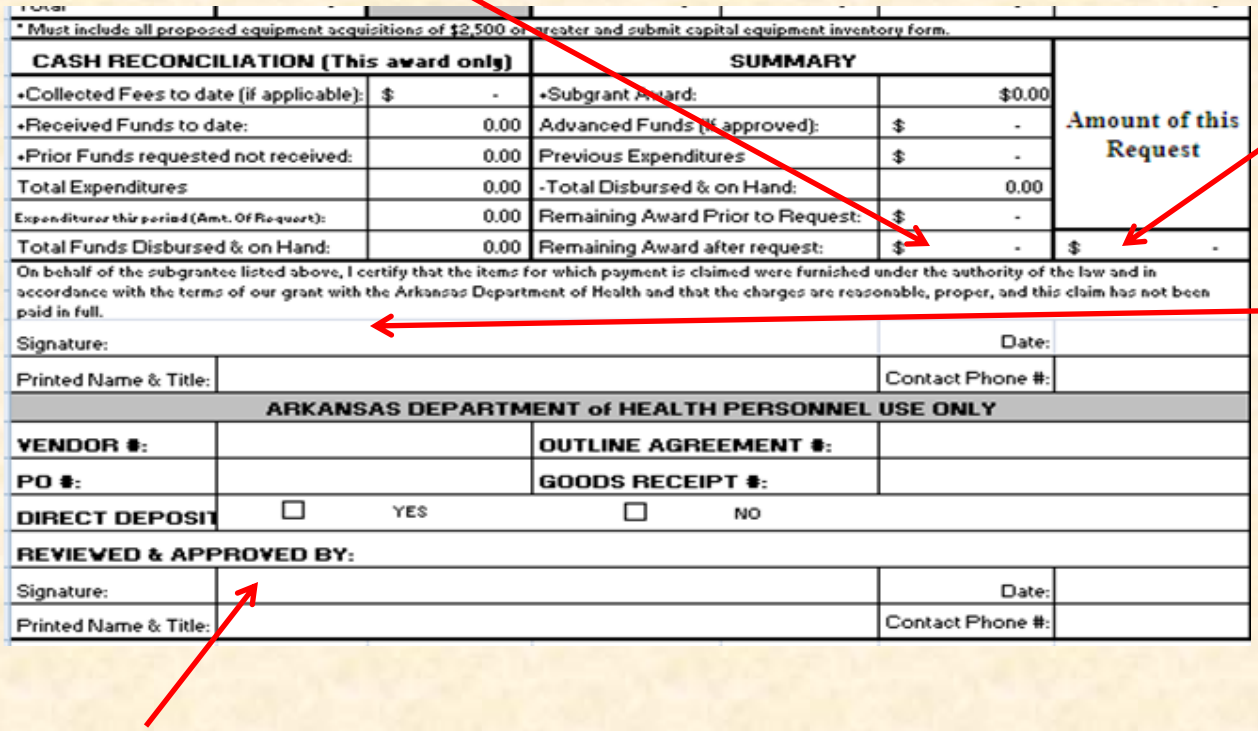
# Street Address			City		State	Zip
Budget Categories	**Requested Budget**	**APPROVED BUDGET**	**Previous Expenditures**	**Expenditures This Period**	**Total Expenditures**	**Remaining Budget**
Regular Salary	-	-	-	-	-	-
Fringe	-	-	-	-	-	-
Travel	-	-	-	-	-	-
M & O	-	-	-	-	-	-
Other (bring forward from Page 2)	-	-	-	-	-	-
Sub-Total	-	-	-	-	-	-
*Capital	-	-	-	-	-	-
Indirect Cost	-	-	-	-	-	-
Collected Fees	-	-	-	-	-	-
Total	-	-	-	-	-	-

* Must include all proposed equipment acquisitions of $2,500 or greater and submit capital equipment inventory form.

The Requested Budget, Approved Budget, Expenditures This Period, Total Expenditures, and Remaining Budget should be filled out in "Other" on page one if amounts are entered on page two

Reimbursement Request/Invoice

If a grantee is requesting the entire grant amount, there should not be any figures listed in the Remaining Award after request box.



* Must include all proposed equipment acquisitions of $2,500 or greater and submit capital equipment inventory form.

CASH RECONCILIATION (This award only)		SUMMARY		
•Collected Fees to date (if applicable):	$ -	•Subgrant Award:	$0.00	
•Received Funds to date:	0.00	Advanced Funds (if approved):	$ -	Amount of this Request
•Prior Funds requested not received:	0.00	Previous Expenditures	$ -	
Total Expenditures	0.00	-Total Disbursed & on Hand:	0.00	
Expenditures this period (Amt. Of Request):	0.00	Remaining Award Prior to Request:	$ -	
Total Funds Disbursed & on Hand:	0.00	Remaining Award after request:	$ -	$ -

On behalf of the subgrantee listed above, I certify that the items for which payment is claimed were furnished under the authority of the law and in accordance with the terms of our grant with the Arkansas Department of Health and that the charges are reasonable, proper, and this claim has not been paid in full.

Signature:		Date:	
Printed Name & Title:		Contact Phone #:	

ARKANSAS DEPARTMENT of HEALTH PERSONNEL USE ONLY

VENDOR #:		OUTLINE AGREEMENT #:	
PO #:		GOODS RECEIPT #:	
DIRECT DEPOSIT	☐ YES	☐ NO	

REVIEWED & APPROVED BY:

Signature:		Date:	
Printed Name & Title:		Contact Phone #:	

This section is for Arkansas Department of Health Personnel Use Only

If figures are entered correctly in all of the columns, the Amount of this Request should be filled in automatically

Please be sure to sign in **Blue Ink**, date, include a printed name and title along with a phone number on these lines.

Please Note: Paid invoices, payroll accounts, copies of checks, etc. must be included with the reimbursement invoice and must equal to or exceed the request