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| PROGRAM INVOICE SUMMARY FORM | |
| To: Department of Public Health, Maternal and Child Health | FOR THE PERIOD OF TOTAL MCH FUND APPROVED |
| AGENCY NAME | |
| STREET ADDRESS: | |
| CITY/STATE: | ZIP CODE: |
| CONTRACT NUMBER: | |
| CONTRACT NAME: | |
| <p>AMOUNT OF TOTAL BUDGET: \$ _____</p> <p>(LESS) NON-MCH FUNDING SOURCES: (-) \$ _____</p> <p>(EQUALS) TOTAL CONTRACT BUDGET: (=) \$ _____</p> <p>TOTAL CONTRACT EXPENSES TO DATE: \$ _____</p> <p>(LESS) MCH PAYMENTS TO DATE: (-) \$ _____</p> <p>(EQUALS) AMOUNT REQUESTED FROM MCH: (=) \$ _____</p> <p>TOTAL CONTRACT BUDGET: \$ _____</p> <p>(LESS) CONTRACT EXPENSES TO DATE: (-) \$ _____</p> <p>(EQUALS) REMAINING CONTRACT FUNDS: (=) \$ _____</p> | <p style="text-align: center;">CERTIFICATION</p> <p>I certify that I am the Facility of said organization, and the revenues for the period shown best of my knowledge and belief shown on these forms with the related balances of the and are in accordance with and directives as required Commonwealth, and City; understands that any and all are made in reliance by Mate the statement I</p> |
| | Prepared by: |
| | Facility Director/Administrator (Signature) |
| | Approved: Director, Maternal & Child Health |
| THIS BUDGET MAY BE REVISED WITH THE WRITTEN APPROVAL OF THE DIRECTOR OF MATERNAL & CHILD HEALTH | |

INSTRUCTIONS – PROGRAM INVOICE SUMMARY FORM INSTRUCTIONS

(This form is to be used by the provider as a cumulative invoice to MCH)

Name:

Identify the organization name and address of the provider preparing the report. This name should be the same party as indicated in the contract with MCH.

Contract Name and Contract Number:

Identify the program for which the budget is being prepared and the City contract number. Obtain the City contract number from page 1 of the contract.

Report Number:

Each report is to be numbered consecutively during the contract period, beginning with Report #1. The last report submitted against the contract should be numbered and marked "Final". (Program Invoice Summary Form Only). When preparing the Program Budget Request Form for a budget revision, indicate the word "Revision" next to For the Period of.

For the period of:

These dates represent the cumulative period for which the report is prepared, for example, where the contract begins on 7/1 the voucher submitted on 8/31 is for the period of 7/1 to 8/31.

Total MCH Funds Approved:

Indicate the amount of MCH funding approved as stipulated in the contract or the amount being requested if this is a budget being submitted for funding.

Certification Statement

Prepared by/Telephone Number:

Indicate the name and phone number of the individual at the corporation who has prepared the budget report/invoice.

Administrator or Executive Director:

The individual who is contractually responsible to MCH must sign and date the budget report/invoice.

Amount of Total Budget: Indicate the total eligible expenses incurred under this contract. This amount is obtained from the total of Section III, Column 1.

Less: Non-MCH Revenue and Income: Deduct the amount of revenue and income as calculated on the total line of Section 1, Program Budget Request Form.

Equals: Total contract Budget: This item is calculated by subtracting Non-MCH Revenues and Income from Amount of Total Budget.

Total Contract Expenses to Date: Indicate the total eligible expenses incurred under this contract from the beginning of the contractual period to date. This amount is obtained from the total of Section III, Column 4.

Less: MCH Payments to Date: Indicate the cumulative total of facility billings to MCH as shown on previous reports submitted to MCH. This amount does not necessarily represent actual cash payment received from MCH at the time of report preparation.

Equals: Amount Requested from MCH: This amount is calculated by subtracting MCH payments to Date from Total Contract Expenses to Date and represent the amount being invoiced to MCH.

Total Contract Budget: This amount reflects the Total Contract Budget as mentioned above.

Less: Contract Expenses to Date: This amount reflects the Total Contract Expenses to Date as mentioned above.

Equals: Remaining Contract Funds: This amount is calculated by subtracting Contract Expenses to Date from Total Contract Budget and represents the amount of available funds.

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| PROGRAM INVOICE SUMMARY FORM | | FOR THE PERIOD OF 7/1/96 |
| To: Department of Public Health, Maternal and Child Health | | TOTAL MCH FUND APPROVED |
| AGENCY NAME ABC Agency | | \$90,000 |
| STREET ADDRESS: 100 Main St. | | |
| CITY/STATE: Phila., PA | | ZIP CODE: 19000 |
| CONTRACT NUMBER:97001 | | |
| CONTRACT NAME: MCH Education | | |
| <p>AMOUNT OF TOTAL BUDGET: <u>\$90,000</u></p> <p>(LESS) NON-MCH FUNDING SOURCES: (-) <u>\$-0-</u></p> <p>(EQUALS) TOTAL CONTRACT BUDGET: (=) <u>\$90,000</u></p> <p>TOTAL CONTRACT EXPENSES TO DATE: <u>\$57,817</u></p> <p>(LESS) MCH PAYMENTS TO DATE: (-) <u>\$52,009</u></p> <p>(EQUALS) AMOUNT REQUESTED FROM MCH: (=) <u>\$5,808</u></p> <p>TOTAL CONTRACT BUDGET: <u>\$90,000</u></p> <p>(LESS) CONTRACT EXPENSES TO DATE: <u>\$57,817</u></p> <p>(EQUALS) REMAINING CONTRACT FUNDS: (=) <u>\$32,183</u></p> | | <p style="text-align: center;">CERTIFICATION</p> <p>I certify that I am the Facility of said organization, and that the revenues for the period shown are the best of my knowledge and belief, and are shown on these forms with the related balances of the organization and are in accordance with the laws, regulations, and directives as required by the Commonwealth, and City; I understand that any and all actions taken are made in reliance by Management on the information in the statement.</p> |
| | | Prepared by: |
| | | Facility Director/Administrator (Signature) |
| | | Approved: Director, Maternal & Child Health |
| THIS BUDGET MAY BE REVISED WITH THE WRITTEN APPROVAL OF THE DIRECTOR OF MATERNAL & CHILD HEALTH | | |

| BUDGET CATEGORIES | ALL SOURCES (COLUMN1) | REPORTED (COLUMN 2) |
|--|--------------------------|------------------------|
| PERSONNEL SERVICES (100) | | |
| 111 - Administrative Salaries | | |
| 112 - Administrative Benefits | | |
| 121 - Client Oriented Services Salaries | \$ 58,749.00 | |
| 122 - Client Oriented Services Benefits | 11,456 | |
| 123 - Staff Development | | |
| <i>Sub-total: Personnel Services</i> | 70,205 | |
| OPERATING EXPENSES (300) | | |
| 301 - Board Expenses | 0 | |
| 302 - Consultant Expenses | 0 | |
| 311 - Rent | 4,718 | |
| 312 - Utilities | 0 | |
| 313 - Insurance | 2,636 | |
| 314 - Housekeeping | 0 | |
| 321 - Communications | 691 | |
| 331 - Office Supplies | 517 | |
| 341 - Medical Supplies | 0 | |
| 342 - Drugs | 0 | |
| 343 - Food & Clothing | 0 | |
| 344 - Rehabilitation Supplies | 1,000 | |
| 351 - Staff Travel | 1,452 | |
| 352 - Client Transport | 0 | |
| 361 - Purchased Physician, etc. | 0 | |
| 362 - Purchased Client Oriented Services | 0 | |
| 371 - Building Maintenance Expense | 0 | |
| 372 - Equipment Maintenance Expense | 0 | |
| 373 - Motor Vehicle Maintenance Expense | 0 | |
| 383 - Other Operating Expenses | 8,781 | |
| <i>Sub-total: Operating Expenses</i> | 19,795 | |
| FIVER ASSETS (400) | | |

