DEPARTMENT OF HEALTH

Date MDH Rec'd Invoice:

Enter Grant Program Name

Grantee Name (as it appears in SWIFT)		Contact Name	
Remit To Address 1		Contact Phone	
Remit To Address 2		Contact email	
City, State, Zip		Invoice Start date	Invoice End date
Grantee SWIFT Vendor #			

Grantee Invoice ID, if applicable:

Expenses

Salaries/Fringe	
Equipment	
Supplies	
Travel	
Contractual	
Other (details on right)	$ 0.00
Subtotal	$ 0.00
Indirect	
Total	$ 0.00

Enter details of "Other" expenses below.

Enter "Other" costs here. These will autosum and autofill in the "Other" field to the left.

Grantee Comments:

Certification Section: By signing this report, I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2,1001,1343, and Title 31, Sections 3729-3730 and 3801-3812.

Grantee Authorized Signature Date:

* Invoice must be signed by the official of the grantee agency with the authority to submit these expenses for payment for this grant.

For MDH Use Only

Okay to Pay: Grant Manager Approval: Date:

PO #:	**Line #:**	Amount to pay:
PO #:	**Line #:**	Amount to pay:
PO #:	Line #:	Amount to pay:
PO #:	Line #:	Amount to pay:

Program Invoice ID: see this link for more information

Total Payment: $ 0.00

Program Financial Approval:

Notes for FM: