BPHC Ryan White Part A Funding

Monthly Invoice

Subrecipient Name:	**ENTER SUBRECIPIENT NAME HERE**
Pay To:	**WRITE COMPLETE SUBRECIPIENT NAME**
Address:	**ENTER AGENCY ADDRESS HERE**

INFECTIOUS DISEASE BUREAU USE ONLY	
APPROVED FOR PAYMENT	
Date:	

Bill To:	Boston Public Health Commission Procure to Pay Office 1010 Massachusetts Avenue Boston, MA 02118

Federal Grant Number	H89HA00011
RW Part A ALN:	93.914

Part A Service:	**ENTER FUNDED SERVICE HERE**
Activity Number:	**3536002**
BPHC PO Number:	**Enter new Fiscal Year PO**

Invoice Submission Date:	**Enter submission Date**
Billing Period:	**Enter Billing Period**
Invoice Number: Cannot exceed 20 characters. Letters and numbers only. No special characters or spacing.	**RW23** [Insert MONTH & SERVICE abbrev.]

DIRECT CARE STAFF	*FTE*	*Budget (A)*	*Amount this Invoice (B)*	*Cumulative Billing (C)*	*Remaining Balance (D)*
Program Director	*0.00*	*$0*	*$0*	*$0*	*$0*
Medical Case Manager	*0.00*	*$0*	*$0*	*$0*	*$0*
Medical Case Manager	*0.00*	*$0*	*$0*	*$0*	*$0*
		$0	*$0*	*$0*	*$0*
Sub-total	*0.00*	*$0*	*$0*	*$0*	*$0*
Fringe	*30.00%*	*$0*	*$0*	*$0*	*$0*
Personnel Totals		***$0***	*$0*	*$0*	*$0*
OTHER DIRECT CARE COST					
Local Travel		*$0*	*$0*	*$0*	*$0*
Staff Training		*$0*	*$0*	*$0*	*$0*
Program Supplies		*$0*	*$0*	*$0*	*$0*
		$0	*$0*	*$0*	*$0*
Sub-total		*$0*	*$0*	*$0*	*$0*
DIRECT CARE TOTAL		*$0*	*$0*	*$0*	*$0*
ADMINISTRATIVE COST					
Program Director	*0.00*	*$0*	*$0*	*$0*	*$0*
Program Rent	*0%*	*$0*	*$0*	*$0*	*$0*
ADMINISTRATIVE COST TOTAL		*$0*	*$0*	*$0*	*$0*
TOTALS EXPENSE		***$0***	*$0*	*$0*	*$0*

Invoice Amount ***$0***

I hereby certify that the bills, receipts, and payroll documentation attached to this invoice are expenditures solely associated with the Ryan White Part A funding.

Prepared by:	*Authorized by:*
Contact Name:	**Name:**
Phone:	**Title:**
Email:	**Signature (blue ink):**

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Program Director	*0.00*	*$0*	*$0*	*$0*	*$0*
Medical Case Manager	*0.00*	*$0*	*$0*	*$0*	*$0*
Medical Case Manager	*0.00*	*$0*	*$0*	*$0*	*$0*
		$0	*$0*	*$0*	*$0*
Sub-total	*0.00*	*$0*	*$0*	*$0*	*$0*
Fringe	*30.00%*	*$0*	*$0*	*$0*	*$0*
Personnel Totals		***$0***	*$0*	*$0*	*$0*
OTHER DIRECT CARE COST					
Local Travel		*$0*	*$0*	*$0*	*$0*
Staff Training		*$0*	*$0*	*$0*	*$0*
Program Supplies		*$0*	*$0*	*$0*	*$0*
		$0	*$0*	*$0*	*$0*
Sub-total		*$0*	*$0*	*$0*	*$0*
DIRECT CARE TOTAL		*$0*	*$0*	*$0*	*$0*
HHS INDIRECT APPROVED RATE					
Ryan White Indirect Rate Cap	*10%*	*$0*	*$0*	*$0*	*$0*
HHS INDIRECT APPROVED RATE COST TOTAL (10% Cap)		*$0*	*$0*	*$0*	*$0*
TOTALS EXPENSE		***$0***	*$0*	*$0*	*$0*

Invoice Amount ***$0***

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Prepared by:	*Authorized by:*
Contact Name:	**Name:**
Phone:	**Title:**
Email:	**Signature (blue ink):**