DEPARTMENT OF HEALTH

625 ROBERT ST N
PO BOX 64975
ST PAUL, MN 55164-0975

Sexual Risk Avoidance Education (SRAE) Quarterly Invoice

FOR MDH USE ONLY (Complete by MDH Staff)	
Vendor ID/Loc. Code	

Date invoice received by MDH	

Mail To:	Minnesota Department of Health Child and Family Health Division
Grant Manager	Emily McDowell
Phone number	651-201-3985
Email Address	health.MCHInvoices@state.mn.us

Today's Date:

Agency Information

Agency Name	
Street Address	

Remit Address (If different)

Agency name	
Street Address	

Name of person who completed this form			
Telephone Number		Email Address	
Reporting Period dates (From)		(To)	

INVOICE REFERENCE #
(Provide a tracking # if you would like)

Note: Budget changes of more than 10% to any line-item require approval before costs are incurred. Budget changes of 10% or less do not required approval but require notification to MDH

Please DO NOT alter the invoice. THANKS!
Complete contact information at the top of the form.
Please check address and reporting date before submitting invoice to prevent delay in payment. Address MUST match SWIFT exactly. THANKS!

CATEGORY OF EXPENDITURE	Enter actual quarterly expenditures by line item for the time being reported. Current Expenditures	Enter actual quarterly Match by line item for the time being reported as required in your grant agreement. Current Match
Salaries and Fringe		
Contractual Services		
Travel Expenses		
Supplies Expenses		
Other (provide detail below) DO NOT ENTER IN THIS CELL		
Category Expenses	0.00	0.00
*Other Expenses	0.00	0.00
SUB TOTAL	0.00	0.00
**Indirect Costs (Max 10% of Sub		
Total amount	0.00	0.00

**Includes telephone, postage, print, copy, and equipment under $5,000.00*
***Federally approved rate, Maximum of 10%, multiplied by Sub Total*

ORIGINAL CERTIFICATION SIGNATURE

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the State and Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Section 3729-3730 and 3801-3812).

Authorized Signature:		**Date:**	

MDH Grant Manager Signature		**Date:**	

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Naming Convention: MDH.SRAE.93.235.STATE. R.Q.

PO #	Line	Fund	Depart ID Name	Approp ID	Project ID	Activity ID	Amount
		3000	H123	H12	H12H		
PO #	Line	Fund	Depart ID Name	Approp ID	Project ID	Activity ID	Amount
		3000	H123	H12	H12H		

Contract #		Voucher ID		Paid Date	

Processed by:		Date Sent to FM		Rev. 1.5.2023