Minnesota Department of Health

# Attachment B: Invoice Template YOUTH SUICIDE PREVENTION learning collaborative GRANT

## Invoice

*To obtain this information in a different format, call: 218-332-5167. Printed on recycled paper.*

Minnesota Department of Health program information

|  |  |
| --- | --- |
| **Program Name:** | Youth Suicide Prevention Learning Collaborative Grant |
| **Division/Section:** | HPCD/IVPS Section |
| **Grant Manager:** | **​​**Click or tap here to enter text.**​** |
| **Email:** | **​​**Click or tap here to enter text.**​** |
| **Phone Number:** | **​​**Click or tap here to enter text.**​** |

Grantee information

|  |  |
| --- | --- |
| **Organization:** | **​​**Click or tap here to enter text.**​** |
| **Invoice Contact:** | ​​Click or tap here to enter text.​ |
| **Email:** | **​​**Click or tap here to enter text.**​** |
| **Phone Number:** | **​​**Click or tap here to enter text.**​** |
| **Billing Period:** | **​​**Enter date(s) of billing period (Quarterly or Monthly) **​** |
| **Grant/Contract Period:** | ​​Click or tap here to enter text.​ |

Expenditures

|  |  |
| --- | --- |
| **Line Item** | **Amount Spent in this Billing Period** |
| Salary and Fringe Benefits: | $ ​Enter dollar amount​ |
| Contractual Services: | $ ​Enter dollar amount​ |
| Travel: | $ ​Enter dollar amount​ |
| Supplies and Expenses: | $ ​Enter dollar amount​ |
| **Subtotal:** | $ ​Enter dollar amount​ |
| Administrative Costs: | $ ​Enter dollar amount​ |
| **Total Expenses for Reimbursement:** | $ ​Enter dollar amount​ |

*I declare that no part of this claim has been previously billed to MDH and reflects only charges that conform and are consistent with the description and conditions of the grant agreement work plan and budget.  I also declare that the data on this document is correct and all transactions that support this claim were made in accordance with all applicable Federal and State statutes and regulations.*

|  |  |
| --- | --- |
| **Grantee Signature** | **Date** |
| Sign here | date |

## For MDH program use only

|  |  |
| --- | --- |
| **Date Invoice Received by Grant Manager:** | ​​Click or tap here to enter text.​ |
| **Date Invoice Approved by Grant Manager:** | ​​Click or tap here to enter text.​ |
| **Amount Approved by Grant Manager:** | ​​Click or tap here to enter text.​ |
| **Additional Comments:** | ​​Click or tap here to enter text.​ |

|  |  |
| --- | --- |
| **SWIFT VN ID#:** | ​​Click or tap here to enter text.​ |
| **Invoice Code:** | ​​Click or tap here to enter text.​ |
| **PO #:** | ​​Click or tap here to enter text.​ |
| **Invoice Total:** | ​​Click or tap here to enter text.​ |

|  |  |
| --- | --- |
| **MDH Program Approver Printed Name and Signature** | **Date** |
| Sign here | date |

*The Invoice Template was last updated by the Agency Project Planning Office 4/17/2023*

Minnesota Department of Health  
Suicide Prevention Unit  
625 Robert St. N  
PO Box 64975  
St. Paul, MN 55164-0975   
651-201-5400   
[health.suicideprev.mdh@state.mn.us](mailto:health.suicideprev.mdh@state.mn.us)   
[www.health.state.mn.us](http://www.health.state.mn.us/)

4/23/2024

*To obtain this information in a different format, call: 651-201-5400*