

# Attachment H: Sample Invoice TemplateSexual Violence Prevention Grant Requests for Proposals

## MDH Program Information

Sexual Violence Prevention Program

Violence Prevention Programs Unit

Minnesota Department of Health

MDH Contact: Julia Tindell, julia.tindell@state.mn.us

Minnesota Department of Health
PO Box 64975
Saint Paul, MN 55164-0975
www.health.state.mn.us

## Grantee Information

Grantee Name (as it appears in SWIFT):

Grantee Address:

Grantee SWIFT Vendor #:

Invoice Billing Period:

Contact Name:

Contact Email:

Contact Phone:

Contract Period:

Expenses

|  |  |  |
| --- | --- | --- |
| Line # | Line Item | Amount spent in this billing period\* |
| Line 1 | Salary and Fringe | $ |
| Line 2 | Contractual Services | $ |
| Line 3 | Travel | $ |
| Line 4 | Supplies | $ |
| Line 5 | Other | $ |
| **Subtotal** | **Subtotal** | $ |
| Indirect costs | **Indirect costs (if applicable)**: no more than 5% of total direct costs for invoice period | $ |
| Total expenses | **Total expenses for this invoice** | $ |
| Total reimbursement | **Total reimbursement** | $ |

\*Supporting documents for these expenses are required to be retained for six years.

Grantee Comments:

**Certification Section:** 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 purpose and objectives set forth in the terms and conditions of the State/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)

**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 MDH Use Only

[ ]  Okay to Pay

Is this the final invoice? [ ]  Yes [ ]  No

Grant Manager Approval:

Date:

| PO #:  | Line #:  | Amount to Pay: $ |
| --- | --- | --- |
| PO #:  | Line #:  | Amount to Pay: $ |
| PO #:  | Line #:  | Amount to Pay: $ |
| PO #:  | Line #:  | Amount to Pay: $ |

**Total Payment:$**

Program Invoice ID:

Program Financial Approval:

Notes for Financial Management:

Minnesota Department of Health
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St. Paul, MN 55164-0975
651-201-5484
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[www.health.state.mn.us](http://www.health.state.mn.us/)

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To obtain this information in a different format, call: 651-201-5484