DEPARTMENT OF HEALTH

Capacity Strengthening Grant Invoice

Submit invoices monthly to **health.capacity@state.mn.us** according to the schedule in your grant agreement.

Date: _____ Grantee: _____

Address: _____

Contact: _____ Phone: _____ Email: _____

Billing period (dates) From: _____ To: _____

	General Funds	
Salary and Fringe		
Contractual Services		
Travel		
Supplies		
Other		
SUBTOTAL	0	
Indirect *Use rate in approved budget*		
	Invoice Total:	0

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 require approval but require notification.*

Please email budget change requests and notifications to your grant manager.

ORIGINAL CERTIFICATION SIGNATURE

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.

Authorized Official Signature: _____ Date: _____

Electronic signatures are accepted as legally binding.

Comments:

FOR MDH USE		
	PO #:	Vendor ID:
	Activity Code:	Location Code:
	PO Line #:	
	Approved Amt:	
	Processed by:	