



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 COMMUNITY FOOD AND NUTRITION ASSISTANCE
 COMMODITY SUPPLEMENTAL FOOD PROGRAM
RECORD OF EXPENDITURES AND ADMINISTRATIVE CLAIM

Attachment 8.1

NAME AND ADDRESS OF CONTRACTOR	CONTRACT NUMBER	UNIQUE INVOICE NUMBER
	EXPENDITURES FOR THE MONTH OF: (MM/YY)	
SALARIES AND FRINGE BENEFITS		
TELEPHONE		
POSTAGE		
PRINTING		
OFFICE SUPPLIES (LIST)		
EQUIPMENT (LIST): PRIOR APPROVAL REQUIRED		
TRAVEL (STAFF TRAVEL) ESTIMATED MILES PER MONTH x 12		
TRANSPORTATION COSTS		
SPACE AND FACILITIES		
OTHER COSTS (LIST)		
TOTAL DIRECT COSTS		
INDIRECT COSTS (MAY NOT EXCEED 8% OF DIRECT COSTS)		
GRAND TOTAL ALL COSTS		
SIGNATURE		
SIGNATURE BY THE AUTHORIZED REPRESENTATIVE CERTIFIES THAT:		
<ul style="list-style-type: none"> A. THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND THAT RECORDS ARE AVAILABLE TO SUBSTANTIATE THE ABOVE EXPENDITURES. B. REIMBURSEMENT SHALL BE CLAIMED ONLY FOR ALLOWABLE PROGRAM COSTS. C. DEPARTMENT OFFICIALS MAY VERIFY INFORMATION. D. THE AUTHORIZED REPRESENTATIVE UNDERSTANDS THAT INFORMATION IS BEING GIVEN IN CONNECTION WITH THE RECEIPT OF FEDERAL FUNDS, AND THAT DELIBERATE MISREPRESENTATION MAY SUBJECT THE AUTHORIZED REPRESENTATIVE TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL CRIME STATUTES. 		
SIGNATURE OF CSFP AUTHORIZED REPRESENTATIVE		TITLE
SOCIAL SECURITY NUMBER		DATE
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES USE ONLY		
APPROVED BY	TITLE	DATE