MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
COMMODITY SUPPLEMENTAL FOOD PROGRAM

RECORD OF EXPENDITURES AND ADMINISTRATIVE CLAIM

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)	$
TRANSPORTATION COSTS	$
SPACE AND FACILITIES	$
OTHER COSTS (LIST)	$
TOTAL DIRECT COSTS	$
INDIRECT COSTS (MAY NOT EXCEED 15% OF DIRECT COSTS)	$
GRAND TOTAL ALL COSTS	$

SIGNATURE

SIGNATURE BY THE AUTHORIZED REPRESENTATIVE CERTIFIES THAT:

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
	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES USE ONLY

APPROVED BY	TITLE	DATE