COVID-19 OTHER EXPENDITURES REIMBURSEMENT INVOICE for Home and Community Based Service Providers only

Invoice Number	
Tax ID Number	
Provider Name	NPI Number
Provider Address (Street Name, Apartment Number and/or Floor Number)	County
City / State	Zip Code

Detailed Itemization and Description - Required for Payment

Instructions: Supporting documentation detailing each reimbursable expense below must be included with this invoice and may include, but is not limited to items such as: sales receipts, invoices, etc. (Expenses must have already been incurred, as this is a reimbursement). Attach additional sheets as necessary.

Date of Expenditure	Detailed Description of Item of Service Detailed	Detailed Explanation of Why COVID-19 Related	Amount
Personnel Salary			
		Total from additional back-up sheets	
		Total Personnel Salary	$ 0.00
Fringe Benefits			
		Total from additional back-up sheets	
		Total Fringe Benefits	$ 0.00
Travel			
		Total from additional back-up sheets	
		Total Travel	$ 0.00
Equipment			
		Total from additional back-up sheets	
		Total Equipment	$ 0.00
Supplies (could include staff testing)			
		Total from additional back-up sheets	
		Total Supplies	$ 0.00
Contracts			
		Total from additional back-up sheets	
		Total Contracts	$ 0.00

Provider Name:	
NPI Number:	

Summary of Total Expenses

(Please complete "Detailed Itemization" information above. The totals for each category from the detail tab will be populated on this summary)

Personnel	Fringe Benefits	Travel	Equipment	Supplies	Contracts	Total Cost
$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

By submitting this invoice to the State of Missouri, I agree that no service(s) or item(s) on this invoice have been paid, partially or in full, from any other funding (whether state, federal, or private in nature) for that same expense.

☐ I certify under the penalties of perjury set forth in Section 575.040, RSMo, that my statements contained herein are true and correct to the best of my knowledge.

Authorized Signature	
Title	
Date	
Email	
Phone Number	

You may email DHSS.CRF@health.mo.gov **with questions pertaining to this invoice.**

DHSS USE ONLY

Reviewed by:	**Date Payment Processed:**
Date:	**Financial Control Number:**