Invoice/Reimbursement Request 2019-20

Please send this request via e-mail or USPS to:
Matt Crespin, Associate Director
Children's Health Alliance of Wisconsin
(414) 337-4562, telephone
mcrespin@chw.org

Date of invoice: _____

Fiscal agency/Organization: _____
*****Checks will be made out to this entity unless otherwise noted.

Fiscal agent Contact person: _____

Street Address / City / ST / ZIP:_____

Telephone number: _____

Total amount of invoice/reimbursement request(Boxes A-E):

$

Please itemize your request in the space below.

A. Personnel: $

***** Itemize personnel (name, title, FTE, rate of pay, fringes, data) *Data only programs include number of unique children entered and copy of DentaSeal site summery report as documentation. Cost per child for data programs is $3.00 per unique child screened.*

B. Contracted staff costs: $

*Include name and contact information of each subcontractor and rate of pay.

C. Supplies/Other: $

*Include copy of invoice/receipt.

D. Travel: $

*****Include miles traveled and rate of pay or copy of receipts for hotel/meals

E. Equipment: $

*Include copy of invoice/receipt

Authorized fiscal agent signature: _____

Please ensure that requested amounts do not exceed amounts in the approved budget either in total or by category. You will receive payment in 3-4 weeks.