INVOICE GUIDANCE

Invoice # - Leave Blank - HCPF will fill out based on naming convention related to contract with grantee

For detailed instructions, Contact your HCPF - Integrated Care program.

Colorado Department of Health Care Policy and Financing
EXPENDITURE DETAILS for REIMBURSEMENT INVOICE FORM

Organization Name - needs to match W-9

Invoice Period - Dates need to be for services/purchase in the past and within the contract period. Cannot invoice for future services/purchases.

Purchase Order/Encumbrance # - Leave Blank

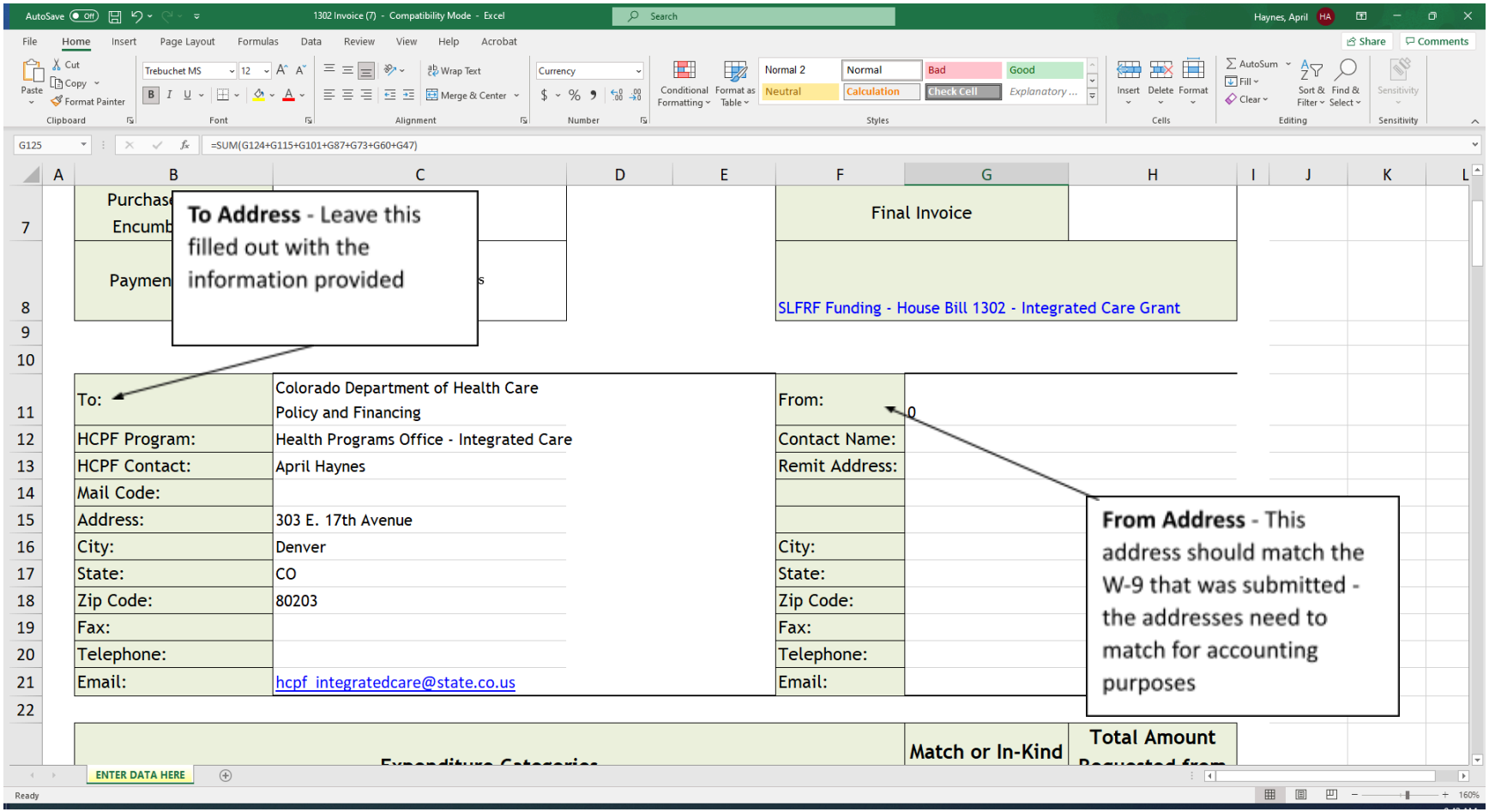
Invoice #	
FEIN	
Purchase Order/ Encumbrance #	
Payment Option	◯ EFT/Direct Deposit - Must be set up* ◯ Mail Reimbursment Check to Remit Address

Organization Name		
Invoice Period		
Final Invoice		
SLFRF Funding - House Bill 1302 - Integrated Care Grant		

Final Invoice - if you are finalizing the contract put "yes" if you are not put "no"

Payment Options - Select "EFT" if you want the funds to be directly deposited; Select "Mail Reimbursement" if you want a mailed check. For EFT - have you turned in the EFT authorization form with a bank letter or voided check? If you haven't then you would select "Mail Reimbursement"

	artment of Health Care ancing	From:	0
	ms Office - Integrated Care	Contact Name:	
		Remit Address:	


1302 Invoice (7) - Compatibility Mode - Excel
G125
=SUM(G124+G115+G101+G87+G73+G60+G47)
Final Invoice
SLFRF Funding - House Bill 1302 - Integrated Care Grant
To Address - Leave this filled out with the information provided
To:
Colorado Department of Health Care Policy and Financing
HCPF Program:
Health Programs Office - Integrated Care
HCPF Contact:
April Haynes
Mail Code:
Address:
303 E. 17th Avenue
City:
Denver
State:
CO
Zip Code:
80203
Fax:
Telephone:
Email:
hcpf_integratedcare@state.co.us
From:
0
Contact Name:
Remit Address:
City:
State:
Zip Code:
Fax:
Telephone:
Email:
From Address - This address should match the W-9 that was submitted - the addresses need to match for accounting purposes
Match or In-Kind
Total Amount
ENTER DATA HERE

Personal Services - This is the position that is working on Integrated Care - most likely the position that you hired for Integrated Care.

Fringe - This is health, life, dental insurance of the monthly position

Total- This is what will be reimbursed for Personal Services for this invoice.

	Expenditure Categories				Match or In-Kind (If Applicable)	Total Amount Requested from HCPF
24	Personal Services	Gross Earnings for invoice period	Fringe	Percent of Actual Time on Contract/ Purchase Order		
25	Beahivoral Health Specialist- Monthly (January)	6,500.00	350.00	75.0000%		$5,137.50
26						$0.00
27						$0.00
28						$0.00
29						$0.00
30						$0.00
31						$0.00
32						$0.00
33						$0.00
34						$0.00
35						$0.00

Gross Earnings - This is the monthly position cost without fringe

Percent of actual time on Contract/PO- This is the percentage of time this position is ALLOWED to be reimbursed for the monthly costs.

**Personal Services are 75% the first year, 40% the second year and 20% the third year. This is to prepare the grantee to sustain the position on their own. Any invoice submitted that shows 100% of the position will be returned for correction. **

Supplies and Operating- Supplies are items such as pens, paper, desk items and other things related to the positions hired or need for the Integrated Care grantee. Operating is for items such as phone bills, internet costs, copier costs or other expenses related to the Integrated Care grantee.

48	Supplies & Operating Expenses		
49			
50			
51			
52			
53			
54			
55			
56			
57			
58			
59			
60	Total Supplies & Operating Expenses	$0.00	$0.00
61	Capital Expenditures		
62			
63			
64			
65			

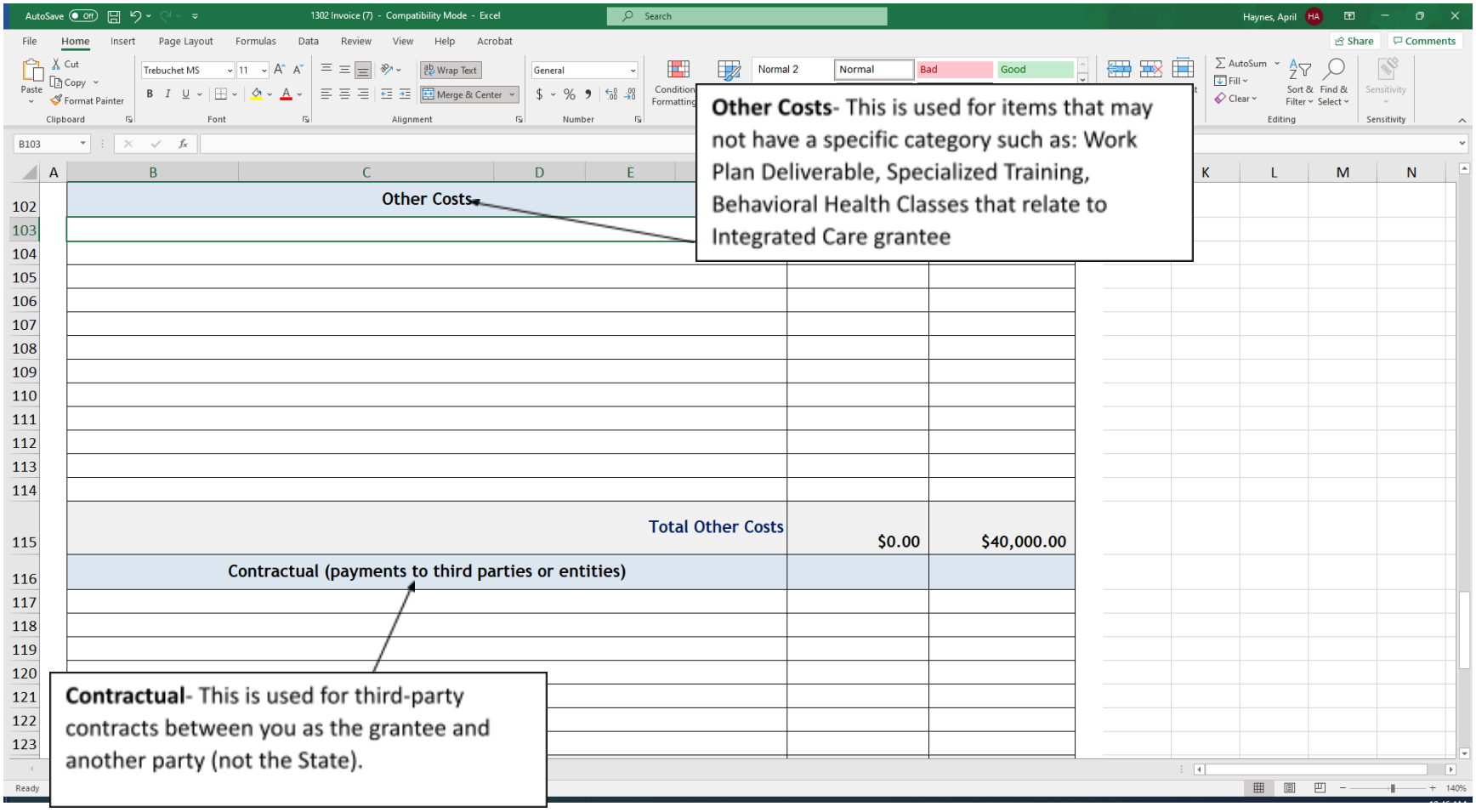
Capital Expenditures- These are items that cost more than $5,000 per item such as an Electronic Health Record, a Multi-Functioning Printer. Please see the guidance located here and here for more information.

Capital Expenses can be no more than 15% of your approved budget.

Travel- This is used to document mileage, conference registration, travel for a conference or other costs associated with travel for the Integrated Care grantee

Equipment- This is used for computers, printers, lab equipment, medical room items all under $5,000 per item.
Note: If invoicing for multiple computers in description display similarly below

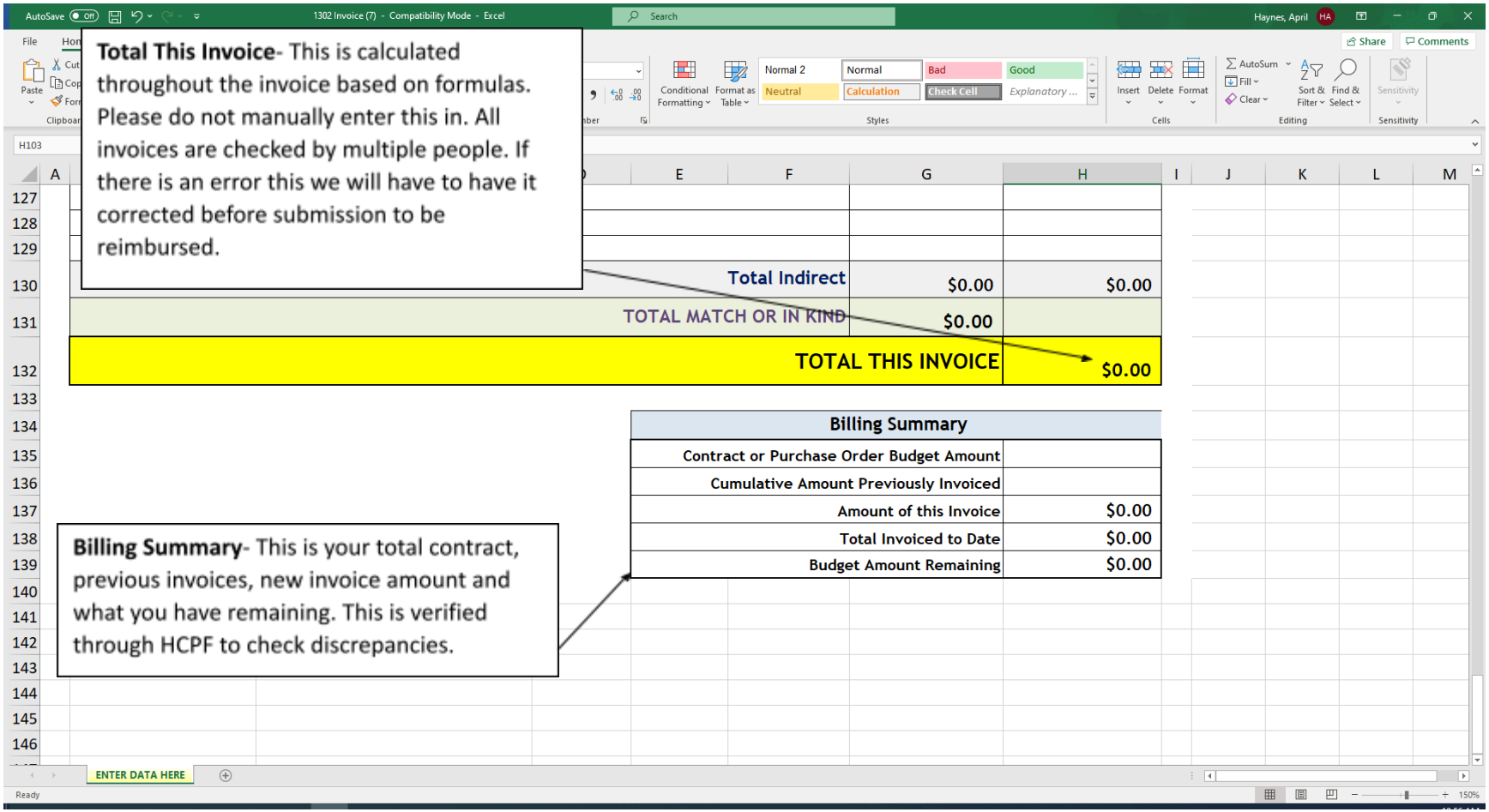
74	**Travel**		
75			
76			
77			
78			
87	**Total Travel**	**$0.00**	**$0.00**
88	**Equipment**		
89	Dell Computer ($1200 x 4)		$4,800.00
90			
91			
92			
93			
94			
95			


1302 Invoice (7) - Compatibility Mode - Excel
Other Costs
Total Other Costs
$0.00
$40,000.00
Contractual (payments to third parties or entities)
Other Costs- This is used for items that may not have a specific category such as: Work Plan Deliverable, Specialized Training, Behavioral Health Classes that relate to Integrated Care grantee
Contractual- This is used for third-party contracts between you as the grantee and another party (not the State).

Indirect- If you budgeted for this - this was calculated at 10% on your line items above. This can be charged on Personal Services, Supplies and travel. Look here for more Federal guidance. This should be added to each invoice.

Total Contractual	$0.00	$0.00
SUB-TOTAL BEFORE INDIRECT	$0.00	$49,937.50
Indirect		
Total Indirect	$0.00	$0.00
TOTAL MATCH OR IN KIND	$0.00	
TOTAL THIS INVOICE		$49,937.50

Billing Summary	
Contract or Purchase Order Budget Amount	
Cumulative Amount Previously Invoiced	
Amount of this Invoice	$49,937.50
Total Invoiced to Date	$49,937.50



Other notable items:

Submission of invoices must be in excel (.xls) format

Once invoice is approved and submitted to accounting it can take up to 10-15 days to receive a mailed reimbursement or an EFT. EFT is typically sooner.