



COLORADO

Department of Health Care
Policy & Financing

Rural Hospital Grant - Invoice Guidance

1. Vendor invoices should be on the hospitals' letterhead. This helps to ensure hospitals are aware of what's being charged and provides them the opportunity to determine capital expenditures.
2. If the hospital has to transfer information to their own letterhead also provide the vendor's original invoice along with your submission.
3. See Section 6.2.2. of the grant agreement for other general information that the invoice should include.
4. Be sure the invoice submitted is legible. Illegible invoices will not clear the Department's approval process.
5. Double check that the amount the vendor is charging is in line with the statement of work (SOW) in Section 4.1.2. of the grant agreement.
6. Identify on the invoice what are capital expenditures and separate them out from other expenditures.
7. Contractor shall invoice the Department on a monthly basis, by the 15th business day of the month following the month the invoice covers.
8. Be sure to deduct each invoice amount from the total grant funds allotted to you for that state fiscal year (SFY). This will help to ensure that you are not spending more than you've been given.
9. On the next page is an example of what an acceptable invoice should look like.

HCPF Invoice Monitoring

The following are some of the areas during the invoice process that HCPF will be keeping track of:

1. Track total grant funds remaining after each invoice is processed for payment.
2. Assess the appropriateness of the expenditure as it relates to the project.
3. Ensure capital expenditures are identified separately from program income or other expenditures.
4. Because invoice payments are deposited directly to the grantee's account, HCPF will ensure that the remittance address on the invoice is the same as the grantee's address (grantee should handwrite their remittance address on the invoice if necessary).

SAMPLE INVOICE

Grantee Name: ABC Hospital
Grant Agreement No.: G24-XXXXXX
Address: 123 XYZ Avenue
City, State, Zip Code

INVOICE #2

Invoice Date: 00/00/00

Product Description	Unit Price	Quantity	Amount	Capital Expenditure
Stationary bikes for physical therapy <i>(cost is less than \$5,000)</i>	\$ 500	9	\$ 4,500.00	No
Cars for patient transportation/mail order deliveries	\$ 20,000	8	\$ 160,000.00	Yes
Building or room to house medical equipment, etc.	\$ 15,000	5	\$ 75,000.00	Yes
Computer to input patient information <i>(cost is less than \$5,000)</i>	\$ 4,000	1	\$ 4,000	No
Total			\$243,500.00	

SAMPLE INVOICE WITH PROGRAM INCOME

Grantee Name: ABC Hospital
Grant Agreement No.: G24-XXXXXX
Address: 123 XYZ Avenue
City, State, Zip Code

INVOICE #2

Invoice Date: 00/00/00

Product Description	Unit Price	Quantity	Amount	Capital Expenditure
Program Expenditures				
Psychiatric provider salary - January 2024	\$ 6,500		\$ 6,500.00	No
Psychiatric provider benefits - January 2024	\$ 1,000		\$ 1,000.00	No
Total			\$ 7,500.00	
Program Income				
Psychiatric fees billed - January 2024	\$ 200	10	\$ 2,000.00	n/a
Total			\$ 2,000.00	
Program Reimbursement				
Program Expenditures			\$ 7,500.00	
Program Income			\$ 2,000.00	
Total Reimbursement			\$ 5,500.00	Expenditures - Income