FORM
A19-1A
(REV. 6/95)

STATE OF WASHINGTON
INVOICE VOUCHER

AGENCY USE ONL

AGENCY NO.	LOCATION CODE
1070	

AGENCY NAME

Health Care Authority
Health Care Services
Medicaid Outreach Unit
PO Box 45530
Olympia WA 98504-5530

INSTRUCTIONS TO VENDOR OR CLAIMANT: Submi
for materials, merchandise or services. Show comp

Vendor's certificate: I hereby certify under penal
and totals listed herin are proper charges for ma
services furnished to the State of Washington, a
and/or services rendered have been provided wi
because of age, sex, marital status, race, creed,
handicap, religion, or Vietnam era or disabled ve

VENDOR OR CLAIMANT

School District

BY
(SIGN IN INK)
(TITLE)

FEDERAL I.D. NO. OR SOCIAL SECURITY NO. (For Reporting Personal Services Contract Payments to I.R.S.)

RECEIVED BY

DATE	DESCRIPTION	QUANTITY	UNIT	UNIT PRICE	AMOUNT
	For services rendered in performance under				
	Contract Number				
	Period of Service: July - September 2020				
	Total Outreach & Linkage T19 Computable Cost				
	FFP Match Rate 50%				
				Total Computable	
				Total FFP Reimbursement	
				Prior Claim Settlement	
		1.42%		Admin Fee	
		5.62%		UMMS Fee	
				Warrant Amount:	

As the Designated Authorizing Representative: I certify the expended amount shown on this A19 invoice is accurate, valid, and represents expenditur
participation (FFP) in accordance of Certification of Public Expenditure (CPE) CFR 42.Sec 433.51; that applied matching funds are not already used a
federal programs and being reimbursed by other federal grants; and any applied donated matching funds have been preapproved for use by Centers f
(CMS). I also certify indirect costs are accurate and allowable under 200 CFR and comply with all applicable rules and regulations. Costs that have be
have not been claimed as direct costs.

PREPARED BY	TELEPHONE NUMBER	DATE	AGENCY APPROVAL

EMAIL ADDRESS

DOC. DATE	PMT DUE DATE	CURRENT DOC. NO.	REF DOC. NO.	VENDOR NUMBER	USE TAX	UBI NUMBER

ACCOUNT NUMBER 30 CHARS	VENDOR MESSAGE 25 CHARS
July - September 2020	Medicaid Admin Claiming

TRANS CODE	FUND	MASTER INDEX		SUB OBJ	SUB SUB OBJ	ORG INDEX	ALLOC	MOS	PROJ	SUB PROJ	PROJ PHAS	AMOUNT	INVOICE DATE	
		APPN INDEX	PROGRAM INDEX											
														Admin F
														UMMS F
												$0.00		

												$0.00			

ACCOUNTING APPROVAL FOR PAYMENT	DATE	WARRANT TOTAL	WARRANT NUMBER

Y

P.R. OR AUTH NO.

t this form to claim payment
lete detail for each item.

lty of perjury that the items
terials, merchandise or
nd that all goods furnished
thout discrimination
color, national origin,
terans status

(DATE)

DATE RECEIVED

FOR AGENCY USE

es eligible for federal financial
s matching funds in other
or Medicare and Medicaid
een treated as indirect costs

DATE

INVOICE # 30 CHARS

Fee

Fee