**INVOICE VOUCHER**

**STATE OF WASHINGTON**

**AGENCY NAME**: Health Care Authority

**LOCATION CODE**: 1070

**HOSPITALIZATION**: Medicaid Outreach Unit

**PO Box 45530**

Olympia WA 98504-5530

**VENDOR OR CLAIMANT**: School District

**DATE**: July - September 2020

**DESCRIPTION**: For services rendered in performance under Contract Number

**QUANTITY**

**UNIT**

**UNIT PRICE**

**AMOUNT**

**Warrant Amount:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Quantity</th>
<th>Unit</th>
<th>Unit Price</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Outreach &amp; Linkage T19 Computable Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFP Match Rate: 50%</td>
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</table>

**TOTAL COMPUTABLE**

<table>
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<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Total FFP Reimbursement</td>
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<tr>
<td>Prior Claim Settlement</td>
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<thead>
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<th>Quantity</th>
<th>Unit</th>
<th>Unit Price</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Admin Fee</td>
<td></td>
<td></td>
<td>1.42%</td>
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</tr>
<tr>
<td>UMMS Fee</td>
<td></td>
<td></td>
<td>5.62%</td>
<td></td>
</tr>
</tbody>
</table>

**INSTRUCTIONS TO VENDOR OR CLAIMANT**: Submit for materials, merchandise or services. Show complete detail for each item.

Vendor's certificate: I hereby certify under penalty of perjury that the items and totals listed herein are proper charges for materials, merchandise or services furnished to the State of Washington, a land or service rendered have been provided without discrimination because of age, sex, marital status, race, creed, handicap, religion, or Vietnam era or disabled veteran participation (FFP) in accordance with the Certification of Public Expenditure (CPE) CFR 42, Sec 433.51; that applied matching funds are not already used as matching funds in other federal programs and being reimbursed by other federal grants; and any applied donated matching funds have been preapproved for use by Centers for Medicaid and Medicare Services (CMS). I also certify indirect costs are accurate and allowable under 200 CFR and comply with all applicable rules and regulations. Costs that have been treated as indirect costs have not been claimed as direct costs.

**PREPARED BY**

**TELEPHONE NUMBER**

**DATE**

**AGENCY APPROVAL**

**EMAIL ADDRESS**

**DOC. DATE**

**PAY 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**

**APPN INDEX**

**PROGRAM INDEX**

**SUB OBJ**

**SUB OBJ**

**ORG INDEX**

**ALLOC**

**MOS**

**PROJ**

**SUB PROJ**

**PROJ PHAS**

**AMOUNT**

**INVOICE DATE**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Admin Fee</td>
<td>$0.00</td>
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<tr>
<td>UMMS Fee</td>
<td>$0.00</td>
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<tr>
<td>ACCOUNTING APPROVAL FOR PAYMENT</td>
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</table>
As the Designated Authorizing Representative: I certify the expended amount shown on this A19 invoice is accurate, valid, and represents expenditures eligible for federal financial participation (FFP) in accordance of Certification of Public Expenditure (CPE) CFR 42.Sec 433.51; that applied matching funds are not already used as matching funds in other federal programs and being reimbursed by other federal grants; and any applied donated matching funds have been preapproved for use by Centers for Medicare and Medicaid (CMS). I also certify indirect costs are accurate and allowable under 200 CFR and comply with all applicable rules and regulations. Costs that have been treated as indirect costs have not been claimed as direct costs.

INSTRUCTIONS TO VENDOR OR CLAIMANT: Submit this form to claim payment for materials, merchandise or services. Show complete detail for each item.

Vendor's certificate: I hereby certify under penalty of perjury that the items and totals listed herein are proper charges for materials, merchandise or services furnished to the State of Washington, and that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, handicap, religion, or Vietnam era or disabled veterans status.
| WARRANT NUMBER |