DEPARTMENT OF HEALTH

625 ROBERT ST N
PO BOX 64975
ST. PAUL, MN 55164-0975

Sexual Risk Avoidance Education (SRAE) Quarterly Invoice Form

FOR MDH USE ONLY (Complete by MDH)	
Vendor ID/Loc. Code	
Date invoice received by MDH	

Submit Invoices Via Email:	
Invoice Email	health.MCHInvoices@state.mn.us
Division	Minnesota Department of Health Child and Family Health
Grant Manager	Emily McDowell
Grant Manager Email	Emily.McDowell@state.mn.us
Grant Manager Phone Number	651-201-3985

Today's Date:

Grantee Recipient or Fiscal Agent Information

Grantee Name	
Street Address	
City, State, Zip code	

Remit Address (If different)

Grantee Name	
Street Address	
City, State, Zip code	

Invoice Reference #	
Enter an invoice reference #. Include invoice month(s) and year. For example: Jan2025 or Jan-Mar2025.	

Name of person who completed this form				
Email Address			Phone Number	
Billing Period:	Start Date		End Date	

The address on this invoice must match the address that you have entered in the Supplier Portal (also referred to as SWIFT).
Please do not alter this invoice template. For any questions, please reach out to the grant manager/specialist directly before submitting this invoice.

	Enter expenditures by line item for the time period of this invoice.
CATEGORY OF EXPENDITURE	**Expenditures**
Salaries & Fringes	
Contractual Services	
Travel Expenses	
Supplies and Expenses	
OTHER (provide detail below)	
Category Expenditure Expenses	0.00
*Other Expenses	0.00
SUB TOTAL	0.00
**Indirect Costs (Max 15% of Sub Total)	
Total Claim Amount Requested	0.00

Note: Budget changes of more than 10% to any line-item requires prior approval before costs are incurred. Budget changes of 10% or less do not require prior approval but requires notification to MDH. All budget changes require submission of the budget modification form.

*Includes telephone, postage, print, copy, and equipment under $5,000.00

**Federally approved rate, Maximum of 15%, multiplied by Sub Total

ORIGINAL CERTIFICATION SIGNATURE

By signing this report, I certify to the best of my knowledge and belief that the information provided herein is true, complete and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2,1001,1343, and Title 31, Sections 3729-3730 and 3801-3812.

Authorized Official Signature:		Date	

FOR MDH USE ONLY

Grant Manager/Specialist Approval:		Date:	

PO #	Line	Fund	Depart ID Name	Approp ID	Project ID	Activity ID	Amount
PO #	Line	Fund	Depart ID Name	Approp ID	Project ID	Activity ID	Amount

Contract #		Voucher ID		Paid Date	

Processed by:		Date Sent to FM		Rev.09.24.25