CHFS Date Stamp Received

CHFS USE ONLY
eMARS PRC #:
DATE INPUT/INITIALS:

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
REIMBURSEMENT REQUEST

Agency Name: _____ **Program Name:** Nurse Aide Training Reimbursement

Address: _____ **Vendor Number:** _____

Contact: _____

Budget Period: 10/01/2024-09/30/2025

E-mail: _____ **Fund Accounting:** 1200

Invoice Period: _____ [X] **Reimbursement**

Invoice Number: _____ [ ] **Final Invoice**

Accounting Template	Approved Budget	Current Month Expenditures	Total Expenditures To Date	Available Balance
		$ -	$ -	$ -
TOTAL	$ -	$ -	$ -	$ -

Contractor Certification: I certify that the costs incurred are taken from the books of account and that such costs are valid and consistent with the terms of the contract, that **Costs are actual expenses and are not estimated**, and that all backup documentation is maintained in this office.

_____ is hereby being requested for payment.

Contractor/Authorized Signature Date

Return Invoice To:
Emily Burgin
KNAT@ky.gov

DMS.Invoice@ky.gov
Division of Fiscal Management
275 E. Main Street, 6W-C
Frankfort, KY 40621
502-564-8196

CHFS USE ONLY:

Contract Specialist Date

Printed Name

Printed Job Title

Program Representative Date

Printed Name

Printed Job Title