

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

**KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
REIMBURSEMENT REQUEST**

Agency Name: _____ _____ Address: _____ _____ Contact: _____ E-mail: _____ _____ Invoice Period: _____ Invoice Number: _____	Program Name: <u>Nurse Aide Training Reimbursement</u> _____ Vendor Number: _____ _____ Budget Period: <u>10/01/2023-09/30/2024</u> Fund Accounting: <u>1200</u> _____ <input checked="" type="checkbox"/> Reimbursement <input type="checkbox"/> Final Invoice
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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: DMS.Invoice@ky.gov
Additional Info Contact: Division of Fiscal Management
emily.hardin@ky.gov 275 E. Main Street, 6W-C
 Frankfort, KY 40621
 502-564-8196

CHFS USE ONLY:

Contract Specialist Date

Program Representative Date

Printed Name

Printed Name

Printed Job Title

Printed Job Title