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: ______________________

E-mail: ______________________

Budget Period: 10/01/2022-09/30/2023

Fund Accounting: 1200

Invoice Period: ______________________

Invoice Number: ______________________

[X] **Reimbursement**

[ ] **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: DMS.Invoice@ky.gov

Additional Info Contact:
emily.hardin@ky.gov

Division of Fiscal Management
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