NOTE: Use your "tab" key to move forward to the next field.



Save Form | Print Form

# Local Oral Health Program Invoice Form

To: LOHPInvoices@cdph.ca.gov

California Department of Public Health
Office of Oral Health

PO BOX 997377, MS 7218

Sacramento CA 95899-7377

**Invoice Date:**

**Invoice No. :**

**Grant Agreement #:**

**Grant Term:**

**Payment Terms:** 45 Net

**Federal ID#:**

## Submit Payment with Invoice to:

| | | |
|---|---|---|
| **Grantee Name:** | | |
| **Street Address:** | | |
| **City:** | **State: CA** | **Zip:** |
| **Telephone No:** | **Fax No.:** | |

## Payment Provisions:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Fiscal Year** | | **Invoice Period** | **From:** | | **To:** | **Total Amount Due:** | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1st Quarter Invoice** | ☐ | **2nd Quarter Invoice** | ☐ | **3rd Quarter Invoice** | ☐ | **4th Quarter Invoice** | ☐ | **Supp Invoice** | ☐ |

### GRANTEE CERTIFICATION

I certify this claim is in all respects true, correct, supportable by available documentation, in compliance with all terms/conditions, laws, and regulations governing its payment under this agreement.

Signature of Authorized Representative

Print Name of Approver

Date:

### STATE CERTIFICATION

I certify this claim is in all respects true, correct, supportable by available documentation, in compliance with all terms/conditions, laws, and regulations governing its payment under this agreement.

Approved for Payment (Signature)

Print Name of Approver

Date:

**Instructions:** Please submit completed and signed invoice with the Invoice Expense Tracking Form via email to the Dental Director at **LOHPInvoices@cdph.ca.gov** and cc your grant manager. Invoices may be submitted quarterly, but not more than monthly, *unless prior approval is given by your grant manager.*

**NOTE:** Invoices that are not complete, missing information or if a revision is required, additional processing time will be needed.

# Local Oral Health Program

## Invoice Expense Tracking

| | |
|---|---|
| **Grant No.:** | |
| **Invoice No.:** | |

| | | | |
|---|---|---|---|
| | **Invoice Period:** | **From:** | **To:** |
| **Grantee Name:** | | | |

| Budget Category | Approved Budget | Actual Expenses This Period | Cumulative Expense To Date | Unexpended Balance |
|---|---|---|---|---|
| **Personnel** | | | | |
| **Fringe Benefits** | | | | |
| **Operating Expenses** | | | | |
| **Equipment (Over $5000)** | | | | |
| **Travel** | | | | |
| **Subcontractors** | | | | |
| **Other Costs** | | | | |
| **Indirect Costs** (25% of Total Personnel Costs or Total Direct Costs) | | | | |
| | | | | |
| **Totals** | | | | |

Remarks: List the Activities/Changes for expenses identified (i.e. 1.3, 1.4, 1.6, 2.2, 2.3, 2.4)

**Instructions:** Please submit completed and signed invoice with the Invoice Expense Tracking Form via email to the Dental Director at **LOHPInvoices@cdph.ca.gov** and cc your grant manager. Invoices may be submitted quarterly, but not more than monthly, *unless prior approval is given by your grant manager.*

**NOTE:** Invoices that are incomplete or missing required information will be returned to LOHPs and may result in processing delay.