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.