

ATTACHMENT B - ARKANSAS DEPARTMENT OF HEALTH
SUBGRANTEE PAYMENT REQUEST FORM

| | | | | | | | |
|---|------------------------------|---------------------------------------|------------------------------------|---------------------------------|---------------------------|-------------------------------|---|
| AWARD PERIOD: | | AGENCY CENTER/BRANCH /SECTION: | Health Advancement/Chronic Disease | | | | |
| AWARD AMOUNT: | \$0.00 | CFDA #: | | CFDA TITLE: | | | |
| Request Period: | | | E.I.N. (Tax ID #): | | | | |
| Subgrantee Name: | | | | Telephone #: | | | |
| Mailing Address: | | | | AR | | | |
| # Street Address | | City | | State | Zip | | |
| Budget Categories | Requested Budget | APPROVED BUDGET | Previous Expenditures | Expenditures This Period | Total Expenditures | Remaining Budget | |
| Regular Salary | - | - | - | - | - | - | |
| Fringe | - | - | - | - | - | - | |
| Travel | - | - | - | - | - | - | |
| M & O | - | - | - | - | - | - | |
| Other (bring forward from Page 2) | - | - | - | - | - | - | |
| Sub-Total | - | - | - | - | - | - | |
| *Capital | | | - | | - | - | |
| Indirect Cost | - | - | - | - | - | - | |
| Collected Fees | - | - | - | - | - | - | |
| Total | - | - | - | - | - | - | |
| * Must include all proposed equipment acquisitions of \$2,500 or greater and submit capital equipment inventory form. | | | | | | | |
| CASH RECONCILIATION (This award only) | | | SUMMARY | | | Amount of this Request | |
| +Collected Fees to date (if applicable): | \$ | - | +Subgrant Award: | | \$0.00 | | |
| +Received Funds to date: | | 0.00 | Advanced Funds (If approved): | \$ | - | | |
| +Prior Funds requested not received: | | 0.00 | Previous Expenditures | \$ | - | | |
| Total Expenditures | | 0.00 | -Total Disbursed & on Hand: | | 0.00 | | |
| Expenditures this period (Amt. Of Request): | | 0.00 | Remaining Award Prior to Request: | \$ | - | | |
| Total Funds Disbursed & on Hand: | | 0.00 | Remaining Award after request: | \$ | - | \$ | - |
| On behalf of the subgrantee listed above, I certify that the items for which payment is claimed were furnished under the authority of the law and in accordance with the terms of our grant with the Arkansas Department of Health and that the charges are reasonable, proper, and this claim has not been paid in full. | | | | | | | |
| Signature: | | | Date: | | | | |
| Printed Name & Title: | | | | Contact Phone #: | | | |
| ARKANSAS DEPARTMENT of HEALTH PERSONNEL USE ONLY | | | | | | | |
| VENDOR #: | | | OUTLINE AGREEMENT #: | | | | |
| PO #: | | | GOODS RECEIPT #: | | | | |
| DIRECT DEPOSIT: | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | | | |
| REVIEWED & APPROVED BY: | | | | | | | |
| Signature: | | | | Date: | | | |
| Printed Name & Title: | Michael Koch, Fiscal Analyst | | | Contact Phone #: | 501-661-2329 | | |

