FAMILY FIRST TRANSITION ACT FUNDS COST REIMBURSEMENT INVOICE

|  |  |
| --- | --- |
| **Provider**: [ Provider name ] | **Contract** # [ Contract # ] |
| **Address:**  [ Provider address ]  | Invoice Number: [Please enter an Invoice Number] |
| **FEID:**  [ Provider FEID ] |  |
| **Telephone**: [ Provider telephone ] | **Contract Year:** SFY 2022-2023 |
| **Reporting Period**: \_\_\_\_\_ **through** \_\_\_\_\_\_\_ | OCA: [Please enter the OCAs being requested here] |
|  |
|  | ***FFTA Categories*** | ***A******Approved Budget*** | ***B******Amount this Invoice*** | ***C******Total Expenditures to Date*** | ***D = (A-B-C)******Budget Remaining*** |
|  | **Installation of Evidence Based Services and Trust-Based Relational Intervention****(OCA FFPEB)** | **[ Amt. from SoF ]** |  |  |  |
|  | **Foster Parent Mentors****(OCA FFPCI)** | **[ Amt. from SoF ]** |  |  |  |
|  | **Residential Settings Transitional Support****(OCA FFPRS)** | **[ Amt. from SoF ]** |  |  |  |
| TOTAL  | **[ Amt. from SoF ]** |  |  |  |
| *By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statement, false claims, or otherwise.* |
| Signature of Provider Agency Official |  | Title of Provider Agency Official |

For questions regarding the completion of this invoice, please email HQ.OCFW.FFTA.Funds@myflfamilies.com.

When completed, please submit this invoice and all of the supporting documentation to your CBC’s DCF Contract Manager.