REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FINANCE
SFN 1763 (11-2024)

Clear Fields

(See reverse for instructions on completing this form).

Vendor/Provider Name		
Address Line 1:		
Address Line 2:		
City	State	ZIP Code

PAYEE CERTIFICATION

I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812. I certify that matching fund requirements have been complied with and that all compliance listed herein is documented for audit purposes.

Is this the final reimbursement request for this contract? (Check a box)

☐ No ☐ Yes

A typed signature is legally binding and equivalent to a handwritten/electronic signature.

Payee Signature

Date

Payee Telephone Number

CONTRACT INFORMATION

Description of Service

HHS Contract Number

Comments

Contract Period
From: To:

Billing Period
From: To:

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)							
Travel							
Consultation Services							
Equipment							
Supplies							
Training							
Other (List Separately)							
Administration/Indirect Costs							
Sub-Total							
Less Advances/Program Income	( )	( )	( )				
TOTALS							

Total Amount Requested for Reimbursement:
(This billing period)

Program Income

Received To Date	Expended To Date	Remaining Balance

DEPARTMENT APPROVAL

A typed signature is legally binding and equivalent to a handwritten/electronic signature.

Program Director
By:

Date

Division Director
By:

Date

Program Accountant
By:

Date

HHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

GENERAL INFORMATION BOXES

1. Description of Service:	Enter a short description of the services provided by your organization under this contract.
2. HHS Contract Number:	Enter the 8-digit Contract Number (###-#####) assigned to the contract by HHS on the line provided (please refer to your organization's **finalized copy** of the contract).
3. Contract Period:	Enter the beginning date and ending date of this contract - including all extension periods by amendment. *(Please note: If the contract number has changed, it is not an extension or amendment - it would then be a new contract - refer to your contract for this information).*
4. Billing Period:	Enter the beginning date and ending date for expenditures being claimed under this reimbursement.
5. Vendor/Provider Name:	Enter the name for your organization, as it should appear on the reimbursement check.
6. Address Lines 1-3:	Enter the full mailing address for your organization, as it should be to mail the reimbursement check.
7. City, State, Zip:	Enter the City, State, and Zip Code for your organization, as it should be to mail the reimbursement check.

SPECIFIC INFORMATION BOXES

Column A:	Enter the total amounts claimed by Expenditure Classification as recorded on the most recently submitted SFN 1763 Column C.
Column B:	Enter the amount being claimed for reimbursement by Expenditure Classification on this SFN 1763.
Column C:	By Expenditure Classification, total the amounts recorded in Columns A and B.
Column D:	Enter the total amount authorized to be expended and reimbursed as indicated in the finalized contract and all amendments.
Column E:	Enter the total amounts indicated as matching expenditures, including In-Kind if specifically allowed, by Expenditure Classification as recorded on the most recently submitted SFN 1763 Column G.
Column F:	Enter the amount being indicated as matching expenditures, including In-Kind if specifically allowed, by Expenditure Classification on this SFN 1763.
Column G:	By Expenditure Classification, total the amounts recorded in Columns E and F.
Sub-Total:	Enter the sum of Expenditures for each column (A through C).
Less Advances/Program Income:	Enter the amount recorded in Column C from the most recently submitted SFN 1763 in Column A. Enter the amount of any advance received from HHS and any Program Income received during this Billing Period in Column B. Total the amounts recorded in Column A and B in Column C.
Totals:	Enter the Sum of the rows "Sub-Total" and "Less Advances/Income" for Columns A through C. Enter the Sum of the detailed Expenditures for Columns D through G.
Program Income Approved to Further Project:	Enter the Program Income Received, Expended and the Remaining Balance when the vendor has been given specific approval from HHS to add Program Income to funds committed to further program objectives.
Is this the final reimbursement request for this contract?:	Enter an "X" in the box marked "no", if further reimbursements will be requested. Enter an "X" in the box marked "yes", if this is the final reimbursement that will be requested under this contract.
Payee Signature:	Signature of authorized individual requesting reimbursement for the organization that will be requested under this contract.
Date:	Date of signature requesting reimbursement by authorized individual.
Payee Telephone Number:	Telephone number of authorized individual signing reimbursement request who can be contacted if necessary.