**Section 630.APPENDIX C Instructions for Completing Reimbursement Certification Form**

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|  | | August 1987 |
| IDPH – OFFICE OF HEALTH SERVICES | | |
| Instructions for Completing the  Reimbursement Certification Form | | |
| Agency Name: | Fill in your agency's name, address and FEIN (Federal Employer's Identification Number or in the case of Local Health Departments, the Comptroller assigned County Identification Number) as it appears in the contract/grant agreement. | |
| Program: | Fill in the name of the Department program for which you are requesting reimbursement. | |
| Contract #: | Fill in the contract number (located in the upper right hand corner of the executed contract/grant agreement). | |
| Billing Period: | Fill in the period covered by the request. The period shown should include the earliest date goods/services were ordered through the latest date services were provided. This period will be used by Department staff to determine proper state, federal and/or project fiscal year. You must submit separate Reimbursement Certification Forms for different state, federal and/or project fiscal years. If you have questions, please consult with Department program or fiscal staff. | |
| Date Submitted: | Fill in date Reimbursement Certification Form is completed or sent to IDPH. | |
| Name/Vendor: | Enter the name of the employee, business or other payee to whom payment was made. | |
| Title/Purpose: | For payroll, enter the title of the employee; for other items, briefly describe the goods or services purchased. (Please provide enough information so that program staff can determine appropriateness to program). | |

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| Period/Date:  Incurred: | For payroll, enter the period covered; for other items, enter the date the goods or services were received. In the case of supplies, equipment and other specific deliverables, it is a good idea to also note the date the order was made. This will assist program/fiscal staff to determine the proper state and/or federal fiscal year to be charged. This is required for all supplies and equipment received in lapse periods (after the end of the state or federal fiscal year). |
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| Voucher/Check  Number: | Enter the voucher or check number for the payment. This establishes the audit trail and is necessary to verify that payment has been made. |
| Gross Amount: | Enter the total amount of the check identified previously or for payrolls the gross pay for the employee. |
| Amount Claimed  from IDPH: | Enter the amount applicable to the program for which this Reimbursement Certification Form applies and for which you are requesting reimbursement. |
| Agency Match/  WIC Admin.: | For those programs which require the agency to provide matching support of Department expenditures, enter the amount of agency supplied match in this column. In most cases this will be a part of the difference between the Gross Amount column and the Amount Claimed from IDPH.  For the WIC program, each agency must identify the allocation of expenditures to either WIC Administration or Nutrition Education. Since there is no matching requirement for WIC, the last two columns are to be used to show this allocation. |
| To further assist Department Program/fiscal staff, please list reimbursements by line item and show a sub-total for each line item.  In many cases, multiple pages will be necessary. In order to save some paper/copying charges, both sides of the Reimbursement Certification Form may be used. Please show the TOTAL on the final page only.  After review and approval, the authorized agency official shall sign the certification (only the final page which shows the TOTAL needs to be signed).  Forward the original and three copies of the Reimbursement Certification Form to:  Illinois Department of Public Health  Office of Health Services, Fiscal Operations Unit  535 West Jefferson, 2nd Floor  Springfield, IL 62761  The Office of the State Comptroller no longer requires vendors to sign or otherwise certify to expenditures on the State of Illinois Invoice-Voucher, Form C-13; therefore, the Reimbursement Certification Form is all that is required to be submitted. The Department fiscal staff will complete the C-13 using information from your Reimbursement Certification Form. | |

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| SD/dm | | | | | | | | |
| 8/12/87 | | | | | | | | |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH  REIMBURSEMENT CERTIFICATION FORM | | | | | | | | |
|  | | | | | | | | Page 1 of 1 |
| AGENCY NAME: Sangamon County  Health Department | | | | PROGRAM: WIC | | | | |
| ADDRESS: 1234 West Fifth Street | | | | CONTRACT #: 87G30027 | | | | |
| BILLING PERIOD: 7/1/87 – 7/15/87  DATE SUBMITTED: 7/22/87 | | | | |
| FEIN NUMBER: 20-0000167 | | | |
| NAME/VENDOR | | | TITLE/PURPOSE | | | PERIOD/DATE  INCURRED | VOUCHER/  CHECK # | |
| Mary Jones | | | Nurse | | | 7/1/87- | Payroll | |
| Sally Smith | | | Nutritionist | | | 7/15/87 | Voucher | |
| Tim Johnson | | | Nutritionist | | |  | #2378 | |
| Nancy Adams | | | Clerk | | |  |  | |
| Betty Clark | | | Clerk | | |  |  | |
| Wanda Campbell | | | WIC Administrator | | |  |  | |
| Subtotal, Personal Services | | | | | | | | |
|  | | |  | | |  |  | |
| Sangamon County  Treasurer | | | Social Security,  Pension Medical  Insurance | | | 7/1/87-  7/15/87 | 278976 | |
|  | | |  | | |  |  | |
| Davis Supply Co. | | | Office Supplies | | | 7/6/87 | 278834 | |
| Capitol Paper Co. | | | Paper Stock | | | 7/10/87 | 278894 | |
| Subtotal, Supplies | | | | | |  |  | |
|  | | |  | | |  |  | |
| Tim Johnson | | | Travel | | | 7/1/87-  7/15/87 | 278975 | |
| GROSS  AMOUNT | | AMOUNT CLAIMED  FROM IDPH | | | Agency Match/  WIC Admin | | Nutrition  Education | |
| 1,145.50 | | 572.75 | | | 477.25 | | 95.50 | |
| 1,200.00 | | 1,200.00 | | | 300.00 | | 900.00 | |
| 1,200.00 | | 900.00 | | | 300.00 | | 600.00 | |
| 500.00 | | 500.00 | | | 500.00 | |  | |
| 550.00 | | 412.50 | | | 412.50 | |  | |
| 1,400.00 | | 1,400.00 | | | 1,150.00 | | 250.00 | |
|  | |  | | |  | |  | |
|  | |  | | |  | |  | |
|  | | 4,985.25 | | | 3,139.75 | | 1,845.50 | |
|  | |  | | |  | |  | |
| 15,728.56 | | 1,096.75 | | | 690.75 | | 406.00 | |
|  | |  | | |  | |  | |
| 327.57 | | 86.40 | | | 86.40 | |  | |
| 250.00 | | 250.00 | | | 200.00 | | 50.00 | |
|  | | 336.40 | | | 286.40 | | 50.00 | |
|  | |  | | |  | |  | |
| 377.82 | | 162.37 | | |  | | 162.37 | |
| TOTAL | | 6,580.77 | | | 4,116.90 | | 2,463.87 | |
| CERTIFICATION | | | | | | | | |
| I hereby certify that the goods and/or services claimed above are necessary expenditures for the program and are a part of the approved budget, that appropriate purchasing procedures have been followed and that payment has not previously been requested or received. | | | | |  | | | |
|  | | | | | | | | |
|  | Authorized Agency Official | | | | | |  | |

(Source: Added at 14 Ill. Reg. 11219, effective July 1, 1990)