

TANF - FHV/TPP/WIC Invoice

FOR MDH USE ONLY	
Vendor ID/Loc. Code	
Date Invoice Received	

Today's Date:

Mail To:	Minnesota Department of Health Child and Family Health Division
Grant Manager	
Email	Health.FHVGrants@state.mn.us

Grantee Information

Grantee Name	
Street Address	

Remit Address (If different)

Grantee name	
Street Address	

INVOICE REFERENCE #
 (Provide a tracking # if you would like)

Name of person who completed this form:		Phone Number	
Email Address:		Reporting Period dates:	

Please check address and reporting dates before submitting invoice to prevent delay in payment.

CATEGORY OF EXPENDITURE	Family Home Visiting Expenditures	Teen Pregnancy Prevention Expenditures	WIC Expenditures	Totals	
Salaries and Fringe					
Contractual Services					
Travel Expenses					
Supplies and Expenses					
Other (expenses must be included in approved budget)					
Other Expenses Total					
SUB TOTAL all Categories					
Indirect Costs *					
Totals					Total Invoice Amount

*Federally approved rate or maximum of 15%, multiplied by Sub Total

ORIGINAL CERTIFICATION SIGNATURE	
By signing this report, I certify to the best of my knowledge and belief that the information 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.	
Authorized Signature:	Date:

FOR MDH USE ONLY

Grant Manager Signature:		Date:	
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Naming Convention:							
PO #	Line	Fund	Depart ID Name	Approp ID	Project ID	Activity ID	Amount
			H12364	H12	H12H	64	

Naming Convention:							
PO #	Line	Fund	Depart ID Name	Approp ID	Project ID	Activity ID	Amount
			H12364	H12	H12H	64	

Contract #		Voucher ID		Paid Date	
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Processed by:		Date Sent to FM		Rev. 12.16.2025
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