MDHS CLAIM SUPPORT FORM (ADVANCED) PAYMENT TYPE

General

The Claim Support (Advanced) form is used by subgrantees on the current needs/cash advance method to requisition operating funds (both administrative and programmatic) that will be needed at a future date. The Claim Support (Advanced) form shall be received by the appropriate MDHS Division 20 days prior to the date on which the funds are needed.

Current Needs Methods

1. *Claim Submission Date*
   Enter the date funds are being requested.

2. *Claim for the Period of*
   The period of the projected cash needs is the period in which all the cash requested will be expended and should not exceed thirty (30) calendar days from the date of submission date. This should be entered in month/year format (November 2016). The date of the final request for cash and projected cash needs shall not exceed the contract ending date.

3. *Claim Number*
   Enter the claim number assigned by MAGIC.

4. *Claim Amount*
   This total represents the sum of columns (6) Federal Claim Amount and (7) State Claim Amount.

5. *Cumulative Claims Requested To Date*
   Cumulative Claims Requested to Date consists of cash received from MDHS as of the date of the request and all request submitted for MDHS for which payment has not been received. Enter the cumulative amount received and any amounts in transit. Only funds awarded by MDHS shall be shown.

6. *Federal Claim Amount*
   Enter federal funds requested for this period.

7. *State Claim Amount*
   Enter state funds requested for this period.

8. *Cumulative Claim To Date*
   This total represents the sum of columns (5) Cumuli Claims Requested to Date, (6) Federal Claim Amount and (7) State Claim Amount.

9. *Other (Sub-Recipient Match)*
   Enter match funds by the sub-recipient for this period.

10. *Signature of Authorized Official*
    The authorized official who must sign the Claim Support Form for Advanced payments is the same official who signed the subgrant agreement with MDHS or the approved authorized signatory official. In case of a signatory designation, an authorization letter shall be required to be on file with MDHS.

11. *Date*
    Enter date the authorized official signed for the Claim Support form.

12. *Program Approval*
    Signature of program representative authorizing payment of this Claim Support form.

**** STATE OF MISSISSIPPI ****

CLAIM SUPPORT FORM: ADVANCED

(1) CLAIM SUBMISSION DATE:

(2) CLAIM FOR THE PERIOD OF:

FUNCTIONAL AREA : 1651 Human Services **(3)CLAIM NUMBER:**

COST CENTER : DIVISION

GRANTEE ID : **(4)CLAIM AMOUNT:**

AGREEMENT NUMBER :

AGREEMENT PERIOD : FROM TO **PROGRAM NUMBER:**

VENDOR NAME : **PROGRAM DESCRIPTION:**

ADDRESS :

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EXPENSE TYPE	DESCRIPTION	AGREEMENT BUDGETED	(5) CUMULATIVE CLAIMS REQUESTED TO DATE	(6) FEDERAL CLAIM AMOUNT	(7) STATE CLAIM AMOUNT	(8) CUMULATIVE CLAIM TO DATE	(9) OTHER (SUB-RECIPIENT MATCH)
10	ADVANCE PAYMENT						
	TOTALS:						

FINAL AUDIT OF THIS PROJECT WILL INCLUDE VERIFICATION OF ABOVE CLAIMED PAYMENT FROM PROJECT DIRECTOR'S SOURCE RECORDS

(10)SIGNATURE OF AUTHORIZED OFFICIAL **(11)DATE** **(12)PROGRAMS APPROVAL**