MDHS CLAIM SUPPORT FORM (COST REIMBURSEMENT) PAYMENT TYPE

General

The Claim Support (Cost Reimbursement) form is used by subgrantees to report monthly cost incurred and to request funds on a cost reimbursement basis. Only one Claim Support (Cost Reimbursement) form submitted per month may be processed.

Cost Reimbursement Methods

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

2. *Claim for the Period of*
   The period of which the cost incurred. This should be entered in month/year format (October 2016). The period of the final Cost Reimbursement Claim Support form shall not exceed the contract ending period.

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 for each line item. 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 sub-recipient for this period.

10. *Signature of Authorized Official*
    The authorized official who must sign the Claim Support Form for Cost Reimbursement 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: COST REIMBURSEMENT

(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 :

:

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	SALARIES						
20	FRINGES BENEFITS						
30	TRAVEL						
40	CONTRACTUAL SERVICES						
50	COMMODITIES						
60	SUBSIDIES, LOANS, & GRANTS						
70	INDIRECT COST						
80	CAPITAL OUTLAY-EQUIPMENT						
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**