

**MONTH-END AGENCY REIMBURSEMENT INVOICE  
FOR CARE/HIPP ENROLLMENT SERVICES  
PART I**

To: California Department of Public Health  
Office of AIDS  
ATTN: CARE/HIPP  
P.O. Box 997426, MS 7700  
Sacramento, CA 95899-7426

From: Organization name: \_\_\_\_\_  
Mailing address: \_\_\_\_\_  
\_\_\_\_\_

Expense period: \_\_\_\_\_ Federal Tax ID Number: \_\_\_\_\_

Original enrollments	_____	(@ \$25.00 each)	\$	_____
Recertifications	_____	(@ \$25.00 each)	\$	_____
HIPP transitions (by the 12 <sup>th</sup> month)	_____	(@ \$100.00 each)	\$	_____
HIPP transitions (after the 12 <sup>th</sup> month)	_____	(@ \$75.00 each)	\$	_____
<b>Total this invoice:</b>			\$	_____

I hereby certify that the amount claimed is accurate and a true representation of the amount owed. I have attached the **required** client documentation for each claim. **I understand that failure to provide the required documentation for each claim will result in nonreimbursement.**

\_\_\_\_\_  
Authorized signature (fiscal representative) Title Date

The Ryan White HIV/AIDS Treatment Modernization Act, allows the California Department of Public Health, Office of AIDS, to authorize the above administrative payment(s), in the amount shown, for the specified period, and to the payee as indicated.

\_\_\_\_\_  
Authorized signature Date

