

**TEXAS DEPARTMENT OF HEALTH**

<b>REQUEST FOR ADVANCE OR REIMBURSEMENT</b>	Approved by Office of Management and Budget, No. 80-RO183		Page of _____ Pages	
	1. Type of payment requested	a. "X" one or both boxes <input type="checkbox"/> Advance <input type="checkbox"/> Reimbursement	2. Basis of Request <input type="checkbox"/> Cash  <input type="checkbox"/> Accrual	
		b. "X" the applicable box <input type="checkbox"/> Final <input type="checkbox"/> Partial		
3. FEDERAL SPONSORING AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH THIS REPORT IS SUBMITTED		4. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER ASSIGNED BY FEDERAL AGENCY	5. PARTIAL PAYMENT REQUEST NUMBER FOR THIS REQUEST	
6. VENDOR ID#	7. RECIPIENT'S ACCOUNT NUMBER OR IDENTIFYING NUMBER		8. PERIOD COVERED BY THIS REQUEST FROM (mo/da/yr)    TO (mo/da/yr)	
9. RECIPIENT ORGANIZATION Name  Number/Street  City/State/Zip		10. PAYEE (Where check is to be sent if different from item #9) Name  Number/Street  City/State/Zip		
<b>11. COMPUTATION OF AMOUNT OF REIMBURSEMENTS/ADVANCES REQUESTED</b>				
PROGRAMS/FUNCTIONS/ACTIVITIES	(a)	(b)	(c)	TOTAL
a. Total program outlays to date (as of date)	\$	\$	\$	\$
b. Less: Cumulative program income				
c. Net program outlays (line a minus line b)				
d. Estimated net cash outlays for advance period				
e. Total (sum of lines c and d)				
f. Non-Federal share of amount on line e				
g. Federal share of amount on line e				
h. Federal payments previously requested				
i. Federal share now requested (line g minus line h)				
j. Advances required by month, when requested by Federal grantor agency for use in making pre-scheduled advances	1st Month			
	2nd Month			
	3rd Month			
<b>12. ALTERNATE COMPUTATION FOR ADVANCES ONLY</b>				
a. Estimated Federal cash outlays that will be made during period covered by the advance				\$
b. Less: Estimated balance of Federal cash on hand as of beginning of advance period				
c. Amount requested (line a minus line b)				\$
<b>13. CERTIFICATION</b>				
I certify that, to the best of my knowledge and belief, the data included on this form are correct and that all outlays were made in accordance with the grant conditions or other agreements, and that payment is due and has not been previously requested.	<i>Signature of Authorized Certifying Official</i>		<i>Date Request Submitted</i>	
	<i>Typed or Printed Name and Title</i>			
	<i>Telephone</i>	<i>A/C</i>	<i>Number</i>	<i>Extension</i>
		<b>Title V Fee-for-Service &amp; Title XX Stand-Alone <sup>1</sup></b>		
		Total Reimbursable Services		
		Less: Program Income		
		TDH Payments		
		Add'l Non-TDH Funded Services	\$0.00	
		Total PI Available	\$0.00	
		Less: PI Expenditures <sup>2</sup>		
		PI to be refunded to TDH	\$0.00	
		<sup>1</sup> Agency does not have Title X and Title XX at the same location		
		<sup>2</sup> PI applied to deliver services		

<b>CASH ON HAND</b>	
Tot Reimb	\$0.00
Net PI	\$0.00
Non TDH Funds	\$0.00
Adv Payback	\$0.00
Net Expenses	\$0.00
Net Payments	\$0.00
Net Expenses	\$0.00
Advances	\$0.00
COH:	\$0.00