INVOICE AND DISBURSEMENT REQUEST FORM

Invoice Date
Billing Month

Remit to:

Send to:
City of Richland Development Services Department Attn: 625 Swift Blvd., MS-19 Richland, WA 99352

HOME-ARP Supportive Services

Award Total

Amount Billed for this Period $0.00
Check if final invoice ☐

Org D8593450
Object 4925
IDIS #
City Vendor #
Subrecipient Agreement #

Fund	Activity	Billed this Period	Total to Date	Balance
153		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
	Total Net City Reimbursement	$ -	$ -	$ -

Project Manager Desk Monitoring	
Authorized Signature	
Eligible, Allowable Costs	
Compliance with Project Budget	

CERTIFICATE

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

SIGNATURE _____ **DATE:** _____

Billing Invoice will only be paid based on provider attaching the required supporting documentation.

Required attachments *(checkmark indicates compliance):*

- ☐ _____
- ☐ _____
- ☐ _____

(Community Services Use Only)

Comments/Notes to Fiscal:

Sufficient Funds Budgeted (fiscal): _____

DATE STAMP

City Use only