**EXHIBIT B4**

**2020 - 2025 BLS Invoice – Mobile Integrated Healthcare (MIH)**

Fire Agency Name

Exhibit: B4 – MIH Invoice and Budget Summary

Contract Period: 1/1/2020 to 12/31/2025

Fire Agency Name

Address 1

Address 2

Name, Title

(111) 111-1111

[email@email.com](mailto:email@email.com)

EMS Division Invoice Contact:

Marlee Fischer ([marfischer@kingcounty.gov](mailto:marfischer@kingcounty.gov))

Public Health—Seattle & King County

Emergency Medical Services Division

401 5th Ave., Suite 1200

Seattle, WA 98104

ALL FIELDS MUST BE COMPLETED FOR PROMPT PAYMENT PROCESSING

|  |  |
| --- | --- |
| **King County Accounts Payable Information** | |
| Purchase Order # |  |
| Supplier Name |  |
| Supplier # |  |
| Supplier Pay Site |  |
| Remit to Address |  |
| Invoice Date |  |
| Invoice # |  |
| Amount to be Paid |  |
| Note to AP |  |
| Payment Type | (Circle One) CHECK or ACH |
| Print on Remittance |  |
| PH Program Name & Phone |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Invoices for services rendered under this contract for the period of:** | **Start Date** | **End Date** |  | *For Public Health Use Only* | | | | |
|  |  |  |  | *Rcv’d* | *FM Review* | *Entered* | *Approved* |
| *Date* |  |  |  |  |
| MM/DD/YY | MM/DD/YY |  | *Initial* |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Project | Organization | Expend Acct | Task | Award | DPH Acct | CPA | CFDA | Amount |
| 1137930 | 830500 | 53180 | 002 | 101752 |  |  |  |  |

*Attach sheet for multiple POETAs*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Direct Costs** | **Budget** | | **Billed to Date** | | **Current Report** | | **Cumulative** | | **Balance** |
| **Personnel Costs** | **$** | | **$** | | **$** | | **$** | | **$** |
| *Salaries* | -- | | -- | | *$* | | *$* | | -- |
| *Overtime* | -- | | -- | | *$* | | *$* | | -- |
| *Benefits* | -- | | -- | | *$* | | *$* | | -- |
| **Program Support** | **$** | | **$** | | **$** | | **$** | | **$** |
| *Supplies & Uniforms* | -- | | -- | | *$* | | *$* | | -- |
| *Planning* | -- | | -- | | *$* | | *$* | | -- |
| *Training* | -- | | -- | | *$* | | *$* | | -- |
| **Vehicle/Vehicle Support** | **$** | | **$** | | **$** | | **$** | | **$** |
| **Technology/Reporting** | **$** | | **$** | | **$** | | **$** | | **$** |
| **Professional Services** | **$** | | **$** | | **$** | | **$** | | **$** |
| **Total Direct Costs** | **$** | | **$** | | **$** | | **$** | | **$** |
|  |  |  | |  | |  | |  | |
| **Grand Total** | $ | $ | | $ | | $ | | $ | |
|  |  |  | | Amount Due | |  | |  | |

I, the undersigned, do hereby certify under the laws of the State of Washington penalty of perjury that this is a true and correct claim for reimbursement services rendered. I understand that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable Federal and State laws. This certification includes any attachments which serve as supporting documentation to this reimbursement request.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | |  |  | |
| Signed | Date |  | PH Program Manager Approval | Date |
|  | |  |  |  |
| Print Name |  |  |  |  |