



2020 - 2025 BLS Invoice – Agencies that operate an MIH program

Fire Agency Name
Exhibit: C – 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

EMS Division Invoice Contact (Please signed PDF of invoice to:
Marlee Fischer (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
MM/DD/YY	MM/DD/YY

For Public Health Use Only				
	Rcv'd	FM Review	Entered	Approved
Date				
Initial				

Project	Organization	Expend Acct	Task	Award	DPH Acct	CPA	CFDA	Amount

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	\$	\$	\$	\$	\$
<i>(Your agency's portion)</i>			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 _____