Attachment G

Ohio Department of Health Help me grow

Early Childhood Home Visiting | Ohio Department of Health

INVOICE

Invoice Date:
Agency Name:
Street Address:
Suite/Office:
City, St, Zip:
Contact Name:
Phone:
Email:

Agency Invoice Number:
OAKS Vendor ID:
Address Code:
HVA ID:

Requested	Deliverable	Amount
☐	Newly Credentialed Home Visitor (**$3,000** per newly credentialed staff)	
☐	Continuous Quality Improvement (CQI) Project (**$5,000** per initial Plan, Do, Study, Act cycle)	
☐	Evidenced Based Model Affiliation Fee (Up to **$5,000** based on actual expense(s)	
☐	Implementation/Operations Plan (**$5,000** per Implementation/Operations Plan)	
☐	Monthly Family Retention Reimbursement	
	TOTAL	

Submit Invoices to:
Ohio Department of Health
Help Me Grow Home Visiting
246 N. High Street, 3 FL
Columbus, Ohio 43215
homevisiting@odh.ohio.gov

To ensure timely processing and reimbursement, please attach supporting documentation to this invoice and submit via email and courtesy copy (CC) your Program Consultant when possible.

ODH Use Only		
Date Received:	☐ Approved ☐ Disapproved Reason for Disapproval:	
Program Consultant Signature		
Provider PO Number:	Processed for Payment:	
Administrator's Signature:		