



# FQHC VAX Secure Invoice Upload

Tracking Number  
**2020565**

Date  
**8/13/2021**

## Contract Information

Please enter the contract number first to automatically populate the fields listed with an asterisk (\*) Please note that these fields are "Read Only" and edits are not permitted on the form.

**FQHC-VAX-172**      **Family Health Centers, Inc.**      **57-0524498**      **7000026038**  
 Contract Number (required)      \* Contractor Name      \* Tax ID      \* SCEIS Number

**Angela Brown**      **Asst. Controlle**      **(803) 531-6961**      **Angela.Brown@myfhc.org**  
 Contact (Full Name)      Title      Phone      EXT      Contact EMAIL

**P. O. Box 1806 3310 Magnolia Street, NE**      **Orangeburg**      **SC**      **29115**  
 \* Address      \* STE #      \* City      \* State      \* Zip

INVOICE NUMBER	INVOICE AMOUNT
T2-061621V	20.00

## Please Upload Invoice for Payment Review

To ensure prompt processing of your invoice ensure that you include the invoice number in the file name that you upload. Please ensure that all required information is included on the invoice. Click below for more details

## Secure Document Upload

Please upload the invoice PDF to our secure website using the buttons below.

T2-0611621V INVOICE

I certify that no other funds have been received or will be reimbursed by any other source for the amounts claimed on this invoice

Signature (required) Click to Sign

*Angela Brown*  
 8/13/2021 4:07:51 PM

**\$20.00**  
 Invoice Total       Yes       No

**The attached invoice is accurate and the invoice total is correct.**

ACC Testing Approval

*Bonner, Melissa*  
 8/23/2021 6:39:34 AM

Budget and Finance Approval

*Samuels, Tierra B.*  
 8/26/2021 4:50:53 PM

Approved Funding      **\$432,450.00**

Approved Invoices to Date      \_\_\_\_\_

Available Funding      **\$432,450.00**

### Payment Processing Instructions

Full Amount \$20.00	31070000	Not Relevant	J0402AZ998
J040X01058580130	5021310000	98000018	

### Accounts Payable Approval

*Robinson, Sharon D.*  
 8/30/2021 9:11:39 AM



If rejecting this form for any reason please provide a brief note to the agency. It will be included in the rejection email notification

# COVID-19 Vaccination Reimbursement Request

Inv. T2-061621V

## Community Vaccination Event Information\*

Provider Name:	FAMILY HEALTH CENTERS, INC.
COVID-19 Vaccine Pin Number:	138050
Location Name:	SANTEE CONFERENCE CENTER
Location Address (incl zip):	1737 BASS DRIVE SANTEE, SC 29142
Date & Times:	6/16/2021 - 8:30AM - 4PM
Total # Vaccinations:	2
Eligible Vaccinations**:	0

## Please select yes or no to the following questions to determine eligible reimbursement:

- Yes Did your organization provide event management, traffic control and logistics for this event?
- Yes Did your organization provide administrative staff for this event?
- Yes Did your organization provide vaccination staff for this event?

## Reimbursement Calculator

Item	Rate	Eligible Event Reimbursement
Event Mgmt, Traffic, Logistics	\$10	\$20
Administrative Staff	\$5	\$0
Vaccination Staff	\$15	\$0
<b>Total Event Reimbursement Amount</b>		<b>\$20</b>

## Additional Cost Summary\*\*\*:

Total additional cost:	
Less other funding/reimbursement:	
Net additional cost:	<b>\$0</b>

**Total Request Amount: \$20**

\* Community Vaccination Events may span multiple days as long as the event location remains the same. All dates should be specified.

\*\* If seeking third-party reimbursement for the services at the event was not appropriate or feasible, then all vaccinations are eligible for reimbursement. If billing third party payers was feasible, then only vaccinations not eligible for insurance reimbursement are eligible for Staffing Reimbursement.

\*\*\* Claiming additional costs requires detailed justification and documentation. Please attach answers to the following questions:

- 1) Summary Description of Request and Costs
- 2) Describe Benefit to the State of South Carolina and Statewide Vaccination Efforts including the future distribution and administering of vaccines.
- 3) Describe activities conducted and outcomes expected or achieved
- 4) Is the cost being covered by any other funding source or insurance? Please explain.
- 5) Were all avenues of funding exhausted before using Vaccine Reserve Account funds? Please explain.

FAMILY HEALTH CENTERS, INC.  
3310 Magnolia Street  
Orangeburg, SC 29115  
VACCINE JUNE 2021

**UNIT 1 COVID VACCINES**

**VACCINE UNIT 2**

**Inv. T2-061621V**

<b>CLAIMS#</b>	<b>SERVICE DATE</b>	<b>Visit Type</b>	<b># OF VAC</b>
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**UNIT 2**

**10 SANTEE CONFERENCE CENTER, 1737 BASS DRIVE, SANTEE, SC 29142**

152662	06/16/2021	Covid Vaccine	1
152670	06/16/2021	Covid Vaccine	1
			<hr/>
			<u>2</u>