



FQHC VAX Secure Invoice Upload

Tracking Number
2020644

Date
8/26/2021

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.

| | | | |
|---|---|--------------------------------|--|
| <u>FQHC-VAX-172</u> Contract Number (required) | <u>Family Health Centers, Inc.</u> * Contractor Name | <u>57-0524498</u> * Tax ID | <u>7000026038</u> * SCEIS Number |
| <u>Angela Brown</u> Contact (Full Name) | <u>Asst. Controller</u> Title | <u>(803) 531-6961</u> Phone | <u>Angela.Brown@myfhc.org</u> Contact EMAIL |
| <u>P. O. Box 1806 3310 Magnolia Street, NE</u> * Address | <u></u> * STE # | <u>Orangeburg</u> * City | <u>SC 29115</u> * State * Zip |

| | |
|-----------------------|-----------------------|
| INVOICE NUMBER | INVOICE AMOUNT |
| <u>T2-072821V</u> | <u>40.00</u> |

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.

T2-072821V 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
8/26/2021 12:34:58 PM

\$40.00
Invoice Total

Yes
 No

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

ACC Testing Approval

Bonner, Melissa
8/30/2021 8:16:53 AM

Budget and Finance Approval

Samuels, Tierra B.
8/31/2021 12:50:03 PM

| | |
|---------------------------|---------------------|
| Approved Funding | <u>\$432,450.00</u> |
| Approved Invoices to Date | <u></u> |
| Available Funding | <u>\$432,450.00</u> |

Payment Processing Instructions

| | | | |
|---------------------|------------|--------------|------------|
| Full Amount \$40.00 | 31070000 | Not Relevant | J0402AZ998 |
| J040X01058580130 | 5021310000 | 98000018 | |

Accounts Payable Approval

Robinson, Sharon D.
9/3/2021 4:43:32 PM



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. T2-072821V

Community Vaccination Event Information*

| | |
|------------------------------|--|
| Provider Name: | FAMILY HEALTH CENTERS, INC. |
| COVID-19 Vaccine Pin Number: | 138050 |
| Location Name: | JOHN FORD COMMUNITY CENTER |
| Location Address (incl zip): | 304 AGNES STREET ST. MATTHEWS, SC 29135 |
| Date & Times: | 7/28/2021 - 8:30AM - 4PM |
| Total # Vaccinations: | 4 |
| Eligible Vaccinations**: | 0 |

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

| | |
|------------|---|
| <u>Yes</u> | Did your organization provide event management, traffic control and logistics for this event? |
| <u>Yes</u> | Did your organization provide administrative staff for this event? |
| <u>Yes</u> | Did you organization provide vaccination staff for this event? |

Reimbursement Calculator

| Item | Rate | Eligible Event Reimbursement |
|---|------|------------------------------|
| Event Mgmt, Traffic, Logistics | \$10 | \$40 |
| Administrative Staff | \$5 | \$0 |
| Vaccination Staff | \$15 | \$0 |
| Total Event Reimbursement Amount | | \$40 |

Additional Cost Summary***:

| | |
|-----------------------------------|------------|
| Total additional cost: | |
| Less other funding/reimbursement: | |
| Net additional cost: | \$0 |

Total Request Amount: \$40

* 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 JULY 2021

UNIT 2 COVID VACCINES

VACCINE UNIT 2

Inv. T2-072821V

| | SERVICE | | | |
|---------|---|---------------|-------------|--|
| CLAIMS# | DATE | VisitType | # VAC | |
| 19 | JOHN FORD COMMUNITY CENTER, 304 AGNES STREET SAINT MATTHEWS, SC 29135 | | | |
| 160815 | 07/28/2021 | Covid Vaccine | 1 | |
| 160728 | 07/28/2021 | Covid Vaccine | 1 | |
| 160707 | 07/28/2021 | Covid Vaccine | 1 | |
| 160790 | 07/28/2021 | Covid Vaccine | 1 | |
| | | | <hr/> | |
| | | | 4 | |
| | | | <hr/> <hr/> | |