GSA
CFDA 93.558

EXHIBIT D

ECECD Requested Monthly Reimbursement for Childcare Services

New Mexico Health Care Authority
Income Support Division
P. O. Box 2348
Santa Fe, New Mexico 87504-2348
Attn: Program Manager

Contractor
Date of Service(s)
Invoice Date
Agreement No
Tax ID No
Invoice No

Early Childhood Education Care Department.

FOR CONTRACTOR USE ONLY

Invoice Amounts

Requested monthly reimbursement for Childcare Services **$ -**

MONTHLY TOTAL

Business Unit:	
Fund#	Dept#
Account #	Sub-Account #
Reporting Category:	Operating Unit:
Bud Reference:	Class:
Project Code:	Activity Code:

Certification
The undersigned certifies that:
1) The amounts invoiced herein are correct and just and that payment therefore has not been received; and
2) agree with the attached transmittal invoice.

Agency's CFO Signature Phone # Date

REMIT PAYMENT TO:

Early Childhood Education Care Department
P.O Drawer 5160
Santa Fe, NM 87502

CERTIFICATION - FOR HCA USE ONLY