

**Exhibit G
HED**

Invoice for Services Rendered

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

Contractor
Month Ending
Invoice Date
Agreement No
Tax ID No
Invoice No

Higher Education Department

FOR CONTRACTORS USE ONLY

FOR CONTRACTOR USE ONLY

Invoice Amounts

Requested monthly reimbursement for Adult Basic Education
Requested monthly reimbursement for Integrated Education and Training Program

\$
MONTH TOTAL

Adult Education

Business Unit	
Fund	
Account	
Reporting Category:	
Bud Reference:	
Project Code:	

IET

Business Unit	
Fund	
Account	
Reporting Category:	
Bud Reference:	
Project Code:	

Certification

The undersigned certifies that:

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

Agency's CFO Signature

Phone #

Date

REMIT PAYMENT TO:

CERTIFICATION - FOR HCA USE ONLY