YEAR X INVOICE X

[Name
SOS
Address
City, State Zip
Phone
provider@isp.com]

To: Lauren Ratner, MPH, MSW
Bureau Chief, Primary Care
Community Health Administration
DC Department of Health
825 North Capitol Street, NE
Suite 3106
Washington, D.C. 20002
HPLRP@dc.gov

Payable to: [Provider name
Home address
City, State Zip]

(*If your address has changed, you must submit a new W-9)*

PO #: **PO[XXXXXX]**

Contract #: **[DCHC-200X-C-00X]**

Billing period: [Initial payment per legislation / 3-month period]

Award period: [Date of contract approval through end date]

Amount: [$0,000.00]

Service: Providing primary care, mental health or dental care services to the medically vulnerable in a Health Provider Shortage Area.

Participant Signature: _____
Signature

_____
Date

Site Contact Signature: _____
Signature

_____
Date

Site Contact: [Medical Director
Site Name
Street address
City, State Zip
(202) 000-0000]

(*If your site contact has changed, you must notify us via email)*

(Please scan and email to HPLRP@dc.gov)