N.C. Department of Health and Human Services, Division of Public Health
Contract Expenditure Report (CER) for Financial Assistance Contracts

CDI/Cancer Prevention & Control-BCCCP	**46364**
DPH Section & Branch	**Contract ID #**
Blue Ridge Community Health Services	NC495627
Contractor Legal Name	**e-Pro PO #**
PO Box 5151 Hendersoville, NC 28793	110086
Remittance Address (address where payments should be sent, even if paid electronically)	**NCFS Supplier #**
Services for BCCCP Eligible Women	**mo/yr of expenditure**
Brief Contract Purpose	**$0.00**
Is Contractor Match REQUIRED by this contract?	**Total Reimbursement**

Place an "X" in the appropriate YES / NO box. YES: | NO: x

Item and Description	Number of Women Served	Rate	DHHS Amount
Client Services			
Breast & Cervical Screening & Diagnostic Services		$325.00	$0.00
Patient Navigation-Only Services for BCCM Application		$50.00	$0.00
Subtotal:			$0.00

THIS SECTION IS FOR DPH USE ONLY.

INVOICE CODING:					**Fund**		**e-Pro**		
Agency	**SFY**	**Account**	**BudgetFund**	**AMU**	**Source**	**Project**	**Purchase Order #**	**e-Pro PO Line**	**$ Amount**
2B00									
2B00									
2B00									
2B00									
2B00									
2B00									
2B00									
2B00									
Row below is to account for MATCH expense credit only. If your contract does *not* require Contractor Match, do not use									
2B00		42996000 - BudgetFund - AMU - 0000000 - 2000 - Project - 000000 ePro PO#: EnterPO **Line N/A**							

Contractor Match is for documentation only. It is not included as part of reimbursement funds to the Contractor.

As chief executive officer or designee of the contracting organization, I hereby certify that the units billed to DHHS on this public payment voucher have been deliv accordance with the conditions of the contract and that, to the best of my knowledge and belief, we have complied with all laws, regulations and contractual provis regulations and contractual provisions that are conditions of payment under this contract. As chief executive officer or designee of the recipient organization, I hereby certify that the cost or units billed for reimbursement on the above Request for Reimbursement were incurred and delivered according to the provisions of agreement. I further certify that any required matching expenditures have been incurred and that, to the best of my knowledge and belief, we have complied with all laws, regulations, and contractual provisions that are conditions of payment under this

Authorized Contractor Printed Name & Title | **Signature** | **Date**

Email to: Appropriate Division Contract Administrator

DHHS-DPH Contract Administrator Signature & Date

DHHS-DPH Branch Head Signature & Date

DHHS-DPH Contract Administrator Printed Name

DHHS-DPH Branch Head Printed Name