

Provider Agency Name & Address
 FDOH in Miami-Dade County
 1350 N.W. 14th St.,
 Miami, 33125

Florida Department of Health
Expenditure/Invoice Report
 Program Name: Patient Care-Consortia
 Area Name: AREA 11A
 Month: Final
 Year: 2022-2023



Report generated on: 05/11/2023

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend
Administrative Services	Final	0	0	\$116,720.00	\$0.00	\$77,074.10	66%
Medical Case Management (including treatment adherence)	Final	579	579	\$175,390.00	\$0.00	\$88,578.75	51%
Mental Health Services - Outpatient	Final	118	428	\$35,000.00	\$0.00	\$13,893.75	40%
Emergency Financial Assistance	Final	358	358	\$713,220.00	\$0.00	\$520,191.31	73%
Housing	Final	0	0	\$375,000.00	\$0.00	\$0.00	0%
Non-Medical Case Management Services	Final	282	282	\$156,572.00	\$0.00	\$147,961.03	95%
Referral for Health Care/Supportive Services	Final	0	0	\$0.00	\$0.00	\$0.00	0%
Clinical Quality Management	Final	0	0	\$71,083.00	\$0.00	\$65,576.11	92%
Planning and Evaluation	Final	0	0	\$36,864.00	\$0.00	\$35,152.92	95%
Totals		1337	1647	\$1,679,849.00	\$0.00	\$948,427.97	

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ADVANCE(S) INFORMATION:

Total Advances	\$0.00
Previous Reductions	\$0.00
Current Reductions	\$0.00
Remaining Advances	\$0.00

Total Contract Amount	\$1,679,849.00
Minus Expended Y-T-D	\$948,427.97
Minus UNPAID Advances	\$0.00
Balance To Draw	\$731,421.03

Total Expenditures this period:	\$0.00
Less Advance Payback this period:	\$0.00

AMOUNT OF FUNDS REQUESTED THIS REPORT: \$0.00

I certify that the above report is a true, accurate and correct reflection of the activities this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

_____ Signature & Title of Provider Agency Official	_____ Date	_____ Contract Manager Signature	_____ Date
		_____ Contract Manager's Supervisor Signature	_____ Date