Florida Department of Health

Expenditure/Invoice Report

Program Name: Patient Care-Consortia

Contract Name: 2024-2025 Miami Dade CHD RW Consortia

Area Name:AREA 11A

Month: August

Report generated on: 10/07/2024

Year: 2024-2025

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend
Administrative Services	August	0	0	$125,294.00	$9,238.97	$52,379.46	42%
Medical Case Management (including treatment adherence)	August	53	9,255	$111,527.00	$10,643.25	$50,076.75	45%
Mental Health Services - Outpatient	August	27	94	$25,000.00	$3,055.00	$13,715.00	55%
Emergency Financial Assistance	August	54	92	$912,456.00	$49,801.14	$212,783.87	23%
Non-Medical Case Management Services	August	15	15	$184,024.00	$9,536.29	$37,954.02	21%
Referral for Health Care/Supportive Services	August	180	180	$203,006.00	$16,214.97	$64,983.74	32%
Clinical Quality Management	August	0	0	$82,071.00	$1,449.85	$7,284.89	9%
Planning and Evaluation	August	0	0	$36,471.00	$1,449.85	$7,284.89	20%
Totals		**329**	**9636**	**$1,679,849.00**	**$101,389.32**	**$446,462.62**	

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend

ADVANCE(S) INFORMATION:

Total Advances	$0.00	Total Contract Amount	$1,679,849.00
Previous Reductions	$0.00	Minus Expended Y-T-D	$446,462.62
Current Reductions	$0.00	Minus UNPAID Advances	$0.00
Remaining Advances	$0.00	Balance To Draw	$1,233,386.38

Total Expenditures this period: $101,389.32

Less Advance Payback this period: $0.00

AMOUNT OF FUNDS REQUESTED THIS REPORT: **$101,389.32**

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**