

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



**Contract Name: 2024-2025 Miami Dade CHD RW
 Consortia**

Area Name: AREA 11A
Month: October
Year: 2024-2025

Report generated on: 01/01/2025

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend
Administrative Services	October	0	0	\$125,294.00	\$19,012.47	\$78,340.08	63%
Medical Case Management (including treatment adherence)	October	69	12,150	\$111,527.00	\$13,972.50	\$76,279.50	68%
Mental Health Services - Outpatient	October	50	17	\$25,000.00	\$1,625.00	\$17,810.00	71%
Emergency Financial Assistance	October	64	137	\$912,456.00	\$67,212.62	\$329,174.26	36%
Non-Medical Case Management Services	October	15	15	\$184,024.00	\$12,439.81	\$56,806.47	31%
Referral for Health Care/Supportive Services	October	147	147	\$203,006.00	\$11,222.33	\$87,721.51	43%
Clinical Quality Management	October	0	0	\$82,071.00	\$2,323.10	\$11,156.73	14%
Planning and Evaluation	October	0	0	\$36,471.00	\$2,323.10	\$11,156.73	31%
Totals		345	12466	\$1,679,849.00	\$130,130.93	\$668,445.28	

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend
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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	\$668,445.28
Minus UNPAID Advances	\$0.00
Balance To Draw	\$1,011,403.72

Total Expenditures this period: \$130,130.93
Less Advance Payback this period: \$0.00

AMOUNT OF FUNDS REQUESTED THIS REPORT: \$130,130.93

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