Provider Agency Name & Address
18255 Homestead Ave
33157
Contract Name:2024_2025 FDOH Miami-Dade County Patient Care-Consortia

Florida Department of Health
Expenditure/Invoive Report
Program Name: Patient Care-Consortia
Area Name:AREA 11A
Month JAN
Year: 2024-2025

Contract Services	Expended Month	# of Clients	Units of Service	Approved Budget	Expended This Month	Expended To Y T D	Rate of Expend
Administrative Services	JAN	0	0	$125,294.00	$4,417.53	$101,669.58	81
Clinical Quality Management	JAN	0	0	$82,071.00	$1,913.30	$15,868.65	19
Emergency Financial Assistance	JAN	116	236	$912,456.00	$0.00	$398,527.68	44
Medical Case Management (including treatment adherence)	JAN	64	10560	$111,527.00	$0.00	$95,789.25	86
Mental Health Services - Outpatient	JAN	15	54	$25,000.00	$0.00	$21,645.00	87
Non-Medical Case Management Services	JAN	18	18	$184,024.00	$0.00	$112,810.82	61
Planning and Evaluation	JAN	0	0	$36,471.00	$1,913.30	$16,104.83	44
Referral for Health Care/Supportive Services	JAN	250	250	$203,006.00	$0.00	$142,205.64	70
TOTALS		**463**	**11118**	**$ 1,679,849.00**	**$ 8,244.13**	**$ 904,621.45**	**53.85135509**

ADVANCE(S) INFORMATION:				
Total Advances	$0.00		Total Contract Amount	$ 1,679,849.00
Previous Advances	$0.00		Minus Expended Y-T-D	$ 904,621.45
Current Advances	$0.00		Minus UNPAID Advances	$0.00
Remaining Advances	0		Balance To Draw	$ 775,227.55

Total Expended This Month	$	8,244.13
Less Advance Payback This period		$0.00
AMOUNT OF FUNDS REQUESTED THIS REPORT	$	8,244.13

I certify that the above report is true, accurate and correct reflection of the activities this period; and the expenditure 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

_____   _____
Contractor Manager Signature   Date

_____   _____
Contract Manager's Supervisor Signature   Date