MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

Subrecipient Annual Financial Report

1. Contractor Name and Complete Address			
2. Contract Number	3. Contract Period (MM/DD/YY)		4. Contractor Identifying Number (optional)
	From:	To:	

5. UEI Number	6. EIN	7. Report Type
		☒ Annual ☐ Final

8. Transactions

Contract Expenditures:

8a. Total contract funds authorized: tab 3 of invoicing tool, B21	
8b. Total expenditures: tab 3 of invoicing tool, O21	
8c. Unspent balance of contract funds (line a minus b): tab 3 of invoicing tool, P21)	

Match Requirements (if required by the contract):

8d. Total match required:	NOT REQUIRED
8e. Total match expenditures:	NOT REQUIRED
8f. Remaining match to be provided (line d minus e):	NOT REQUIRED

9. Remarks: Attach any explanations deemed necessary.

10. Certification: By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal Award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

11a. Typed or Printed Name and Title of Authorized Certifying Official of the Contractor	11b. Telephone (Including Area Code)	11c. Email Address
11d. Signature of Authorized Certifying Official of the Contractor		11e. Date Report Submitted (MM/DD/YY)

MO 580-3091 (10-2022)