HIV / AIDS SERVICE AGREEMENT

INVOICE

Agency: Case Management Forever, Inc.
Mailing Address: One South Six St., NW
Minneapolis, MN 55401

Contract #: A077777
PO #:
Account #: 55360
Center ID#: 581262

Program: Medical Case Management

Funding Period: March 1, 2008 - February 28, 2009

Invoice Period: March 2008

Expenditure Category			**Amounts**	**Subtotals**
Personnel:				
Tier I Case Management Hours		Hours @ $42.75	$0.00	**$0.00**
Tier II & III Case Mangaement Hours		Hours @ $66.17	$0.00	**$0.00**

TOTAL REIMBURSEMENT REQUESTED: $0.00

I certify that to the best of my knowledge and belief, all expenditures reported or payments requested are correct and made for appropriate purposes in accordance with the contract agreement.

Signed: _____ Date: _____

Title: _____

Please send completed invoice to :

Mary Jo Meuleners, Contract Analyst
Hennepin County Human Services and Public Health Department
525 Portland Avenue South, MCL963
Minneapolis, MN 55415-1569