

Monthly Case Management Invoice & FTE Verification

Agency: _____

Invoice Month: _____

RW Part B Monthly Amount: _____

HOPWA Monthly Amount: _____

Ryan White Part B and HOPWA case management is reimbursed by Full Time Equivalent (FTE). Below is the information necessary to make contractual payment and comply with state regulatory reporting requirements.

The following employees were employed under the Part B and/or HOPWA case management contract(s) during the Invoice Month listed above.

Employee Name	Total FTE	% RW Part B	% HOPWA	% Other

Instructions: **Employee Name:** enter all employees who are paid in any part under the RW Part B or HOPWA case management contract (i.e. case managers, eligibility specialists). **Total FTE:** enter in the amount of a FTE each person is employed at your agency. **% RW Part B:** for each employee, enter in the % of the FTE listed in the previous column paid for by RW Part B. **% HOPWA:** same as % RW Part B but for HOPWA. **% Other:** same as RW Part B but for Other funding sources (general revenue, county commission funding, private donations).

Total number of clients served during report period: RW: _____ HOPWA: _____

Clients served are the unique client count (no duplicates) of persons receiving any case management service, including all Direct Care services. This includes persons getting an eligibility determination or update, assistance with a referral, medical care or any documented activity related to case management of the individual client. Clients served by the FTEs listed above.

******This is a mandated State requirement. Make sure your information is accurate before you sign this form.**

I attest the unduplicated client count is correct.

Authorized Signature: _____

Date: _____