Name of FI : ___________________________ Date Submitted: __________________
Address: ___________________________ Submitted By (print): __________________
City, State, Zip: ___________________________ Quarter Ended: __________________

INVOICE

Minnesota Department of Human Services Child Support Enforcement Division FINANCIAL INSTITUTION DATA MATCH AGREEMENT

Quarterly Matching Expense

If your institution uses a Service Bureau, please complete the following:

a. Name of Service Bureau ____
b. Service Bureau fee for FIDM processing $___________

If your institution does not use a Service Bureau, please complete the following:

a. Salary and Fringe $___________
b. Non-salary Expenditures $___________

Total Quarterly Match/Extract Costs $ _________

Financial Institutions are responsible for maintaining detail schedules supporting these expenditure claims for twenty-seven (27) months.

Invoices should be sent to:

FIDM Invoice Clerk DHS-CSED Po Box 64946 St. Paul, MN 55164-0946

DHS – CSED Accounting Information:

Amount:___________ Agency:__________
Doc ID#___________ FY:_____________
Pay #:_____________ Fund #: _________
Date:______________ Org.#:___________