



Memorandum

#22-085

TO: WIC Regional Directors
WIC Local Agency Directors

FROM: Amanda Hovis, Director
Nutrition Education/Clinic Services Unit
Nutrition Services Section

DATE: October 28, 2022

SUBJECT: FFY23 SNAP-Ed Invoice Template and Instructions

Please use the FFY23 SNAP-Ed Invoice Template when billing for SNAP-Ed reimbursement.

The FFY23 SNAP-Ed Invoice Template and Instructions are attached and can be downloaded from Egnyte: <https://txwic.egnyte.com/dl/uLMABU2k7S>.

Please submit invoices to WICInvoices@hhs.texas.gov by the 30th day of the month following the month of expenditures.

Email Subject Format: *MM-DD (date sent) LA# FY23 Month of Service*

If you have questions about SNAP-Ed reimbursement, please contact BeatriceWatson@hhs.texas.gov or WICInvoices@hhs.texas.gov.

STEPS TO COMPLETING WIC PROGRAM SNAP-ED INVOICES

1 Use the attached Excel template tabs for your local agency's specific project funding.

2 Complete the following boxes:

- a. 9 Texas identification number (Parent Agency's)
- b. 12 Purchase Order number (provided by the Program)
- c. 13 Document amount (total amount only)
- d. 14 Payee name / address
- e. 19 Service / Del Date (last day of the month; MM/DD/YY)
- f. 20 Description of goods or services:
 - i. Input agency name
 - ii. Contract Term (already entered)
 - iii. Contract ID: begins with HHS on contract
 - iv. Invoice ID: MMY LA# " *SNAP-Ed - **project abbreviation***"; Obesity Prevention (**OP**), Nutrition on the Go (**NOG**), Breastfeeding Friendly Community Initiative (**BF**), Peer Text (**Peer**), Health Care Provider Research & Campaign (**HCP**)

An example for Nutrition on the Go Invoice for October 2022 Local Agency 02 would be; **1022 LA02 SNAP-Ed - NOG**

- g. 22 Unit Price should indicate **the appropriate cost category(ies)**.
- h. 23 Amounts by category and a total amount.
- i. 24 Contractor Certification information
- j. 25 Name of person completing the invoice

3 The last line is to be completed by the State Agency.

4 When preparing the monthly invoices, please keep each invoice in EXCEL format.

5 Negative Invoices will not be accepted. Error corrections should be recorded at the LA level and invoices should resume when reimbursement is being requested.

6 When submitting the invoices to the state, **attach each invoice separately**. Each invoice should be a separate Excel document.

7 Submit the separate invoices electronically under one email to the WIC mailbox: WICInvoices@hhs.texas.gov.

The SUBJECT LINE on the email should indicate MM-DD (date of email), your LA#, FY23, and Month of Service ; **Example: 11-27 LA01 FY23 Oct Invoices**

8 The State Agency Invoice Team will NOT adjust any amounts billed on the invoices.

10 Training pertaining to this FY23 invoice will be conducted in the beginning of FY23

11 Questions should be emailed to WICInvoices@hhs.texas.gov

SNAP-ED INVOICE FOR ENCUMBERED PAYMENT

1. Archive reference number		2. Agency number 529		3. Agency name Health & Human Services Commission				4. Current document number	
5. Effective date			7. Orig pmt date		CONF	8. Doc agency 529			
9. Texas identification number				10. PDT	11. PCC	12. Purchase Order number		13. Document amount	
14. Payee name / address						15. GSC order number		17-18. STATE AGENCY USE ONLY	
						16. Lease number			
18 SFX 001	Ref Doc	IC	RC	TC	PCA	FY	COBJ	AOBJ	Amount
	APPN	Fund	Pmt due date		Invoice date		Invoice number / Account Number		Invoice Received Date
	DeptID/Speedchart			Requested Payment Date			Interest Control	Reason Code	R
Cap ind		Tag #	AGENCY USE						
18 SFX 001	Ref Doc	IC	RC	TC	PCA	FY	COBJ	AOBJ	Amount
	APPN	Fund	Pmt due date		Invoice date		Invoice number / Account Number		Invoice Received Date
	DeptID/Speedchart			Requested Payment Date			Interest Control	Reason Code	R
Cap ind		Tag #	AGENCY USE						
18 SFX 001	Ref Doc	IC	RC	TC	PCA	FY	COBJ	AOBJ	Amount
	APPN	Fund	Pmt due date		Invoice date		Invoice number / Account Number		Invoice Received Date
	DeptID/Speedchart			Requested Payment Date			Interest Control	Reason Code	R
Cap ind		Tag #	AGENCY USE						
19. SERVICE / DEL DATE	20. DESCRIPTION OF GOODS OR SERVICES					21. QUANTITY	22. UNIT PRICE		23. AMOUNT
Last day of the month mm/dd/yy	Services performed in accordance with Texas WIC contract between Health and Human Services Commission and INPUT AGENCY NAME						Salary		\$\$\$.\$\$
							Fringe Benefits		\$\$\$.\$\$
							Contracts/SubGrants/Agreement		\$\$\$.\$\$
							NonCap Equip/Office Supplies		\$\$\$.\$\$
							Educational Material		\$\$\$.\$\$
							Travel		\$\$\$.\$\$
							Bldg Space Lease/Rental		\$\$\$.\$\$
							Public Owned Bldg Space		\$\$\$.\$\$
							Maintenance/Repair		\$\$\$.\$\$
							Instltl Membership/Subscription		\$\$\$.\$\$
						Equipmt/Capital Expenditures		\$\$\$.\$\$	
						Indirect Cost		\$\$\$.\$\$	
						TOTAL		\$0.00	
24. CONTRACTOR CERTIFICATION					Phone (Area code and number)		25. Entered by		
Contractor Contact Name and Title					Phone (Area code and number)		Date		
26. I approve this invoice for payment and certify that the expenses are true, correct and unpaid. (1) The goods and services covered by the document comply with the requirements of the contracts under which they were purchased; and (2) The Invoices for the goods and services are correct. This payment complies with the General Appropriations Act.									
Program Approver Name					Program NAME WIC		Phone (Area code and number)		Date