



**MONTHLY DATA AND PAYMENT REPORT**  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 ADULT AND AGING SERVICES  
 SFN 269 (7-2024)

Legal Entity Name		
Address		
City	State	ZIP Code

Service Period From (mm/dd/yyyy)	Service Period To (mm/dd/yyyy)
Contract Number	Vendor Number
ASD File Number	

A. Nutrition Education	Units					\$	
B. Nutrition Counseling	Units					\$	
						Congregate Meals C1	Home Del Meals C2
C. Unduplicated Individuals Served							
D. Number of Eligible Units Provided							
E. 1. Required Match Balance	\$	\$	\$	\$	\$	\$	\$
2. Required Match Expended	\$	\$	\$	\$	\$	\$	\$
3. Balance After Expenditure	\$	\$	\$	\$	\$	\$	\$
F. 1. Program Income Received	\$	\$	\$	\$	\$	\$	\$
2. Program Income Expended	\$	\$	\$	\$	\$	\$	\$
G. Contracted Unit Rate	\$	\$	\$	\$	\$	\$	\$
H. Contract Balance	\$	\$	\$	\$	\$	\$	\$
I. Service Period Expenditure	\$	\$	\$	\$	\$	\$	\$
J. Balance After Payment	\$	\$	\$	\$	\$	\$	\$
K. NSIP Payment					\$	\$	\$
SOURCE	FUND	SPEED CHART	PROJECT	ACTIVITY ID	RESOURCE TYPE	PAYMENT	
Title III B	S091	4241	S091	03	FFY	\$	
Title III C1	S092	4242	S092	01	FFY	\$	
Title III C2	S093	4243	S093	01	FFY	\$	
NSIP	S089	4246	S089	01	FFY	\$	
					FFY	\$	
					FFY	\$	
					FFY	\$	
					FFY	\$	
<b>TOTAL PAYMENT</b>						\$	

By signing below, the contract entity is certifying compliance with the match requirements as stated in the contract.

Signature:

Title	Date
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Aging Services Fiscal Approval	Date
Aging Services Administrator Approval	Date
Aging Services Program Accountant Approval	Date