

ATTACHMENT V

SUBCONTRACTOR UTILIZATION REPORT FORM FOR COMMODITIES/SERVICES

DIRECTIONS:
 Vendors working for the Agency for Health Care Administration (AHCA) **must complete and submit this attachment with each invoice submitted for payment.** Questions regarding use of this form should be directed to the Agency's Contract Manager identified in the contract.

AHCA Contract No.: FA

Invoice Number: _____

Invoice Service Period: _____

Check box if no minority subcontractors were used during this period.

INDICATE THE <u>ONE</u> CATEGORY THAT BEST DESCRIBES EACH ORGANIZATION LISTED																				
BUSINESS CLASSIFICATION				CERTIFIED MBE (Supply Ethnic Code)				NON-CERTIFIED MBE (Supply Ethnic Code)				NON-PROFIT ORG.								
NON-MINORITY - A	SMALL BUSINESS (STATE) - B	SMALL BUSINESS (FEDERAL) - C	GOVERNMENTAL AGENCY - E	NON-PROFIT ORGANIZATION - F	P.R.I.D.E. - G	AFRICAN AMERICAN - H	HISPANIC - I	ASIAN/HAWAIIAN - J	NATIVE AMERICAN - K	AMERICAN WOMAN - M	AFRICAN AMERICAN - N	HISPANIC - O	ASIAN/HAWAIIAN - P	NATIVE AMERICAN - Q	AMERICAN WOMAN - R	BOARD IS 51% OR MORE MINORITY - S	51% OR MORE MINORITY OFFICERS - T	51% OR MORE MINORITY COMMUNITY SERVED - U	OTHER NON-PROFIT - V	
LIST NAMES & ADDRESSES OF SUBCONTRACTORS UTILIZED THIS INVOICE PERIOD	SERVICE PROVIDED	LIST AMOUNT PAID TO EACH SUBCONTRACTOR THIS INVOICE PERIOD																		

SUBCONTRACTOR UTILIZATION REPORT FORM CERTIFICATION:

I certify that the information provided in the preceding page is accurate as of the last day of the payment period identified on this form.

(Signature)

(Date)

(Business Name)

(Street Address)

(City, State, Zip Code)

(Phone Number)