State of Illinois
Department of Human Services

Summary Expenditure Documentation Form (EDF)

Printed Name of Person Completing Report: _____

Telephone Number: (include area code) _____ Extension: _____ Date: _____

Email Address: _____

Agency Name: _____

Federal Identification Number: _____ Contract Number: _____

Program Name: _____ Contract Function: _____

AMOUNT	REPORTING MONTH/DATA DUE BY
	July - DUE BY SEPTEMBER 1
	August - DUE BY OCTOBER 1
	September - DUE BY NOVEMBER 1
	October - DUE BY DECEMBER 1
	November - DUE BY JANUARY 1
	December - DUE BY FEBRUARY 1
	January - DUE BY MARCH 1
	February - DUE BY APRIL 1
	March - DUE BY MAY 1
	April - DUE BY JUNE 1
	May - DUE BY JULY 1
	June - DUE BY AUGUST 1
	TOTAL YEAR TO DATE

TITLE OR PURPOSE	TOTAL AMOUNT CLAIMED
PERSONAL SERVICES & FRINGES	
CONTRACTUAL SERVICES:	
TRAVEL:	
SUPPLIES:	
EQUIPMENT:	
ADMINISTRATIVE COSTS:	
TOTAL:	

☐ Revised Revision Date: _____

CERTIFICATION: The undersigned hereby certifies that the goods and/or services claimed above are necessary expenditures for the program, that appropriate purchasing procedures have been followed, that payment has been made as indicated and that reimbursement has not previously been requesting or received.

Signature of Authorized Agency Official: _____ Date: _____

Submit one copy to: Early Intervention
823 East Monroe
Springfield, IL 62701
Or Fax: 217/524-6248