State of Illinois
Department of Human Services - Bureau of Maternal and Child Health

PRIMARY CARE QUARTERLY SUMMARY REPORT

Agency Name: _____

FEIN: _____

IDHS Agreement No.: _____

COST PER QUARTER		DUE BY
$0.00	Quarter 1: Jul, Aug, Sep	OCTOBER 30
$0.00	Quarter 2: Oct, Nov, Dec	JANUARY 30
$0.00	Quarter 3: Jan, Feb, Mar	APRIL 30
$0.00	Quarter 4: Apr, May, Jun	JULY 30
$0.00	Cumulative Cost	

Prepared By: _____

Email Address: _____

Phone: _____

Date Submitted: _____

☐ Revised Report

MONTH				QUARTERLY TOTAL
COST				
NEW PRENATAL CLIENTS				
NEW PEDIATRIC CLIENTS				

I hereby certify that the goods and/or services claimed above are necessary expenditures for the program and are a part of the approved budget that appropriate purchasing procedures have been followed and that payment has not previously been requested or received.

Authorized Agency Official

Name: _____

Title: _____

Date: _____

Signature: _____

MCH Nurse Consultant Approval

Name: _____

Title: _____

Date: _____

Signature: _____