Attach supporting documentation
to the back of this form

STATE OF IOWA

GAX

BUDGET FY	**GENERAL ACCOUNTING EXPENDITURE**		DOCUMENT NUMBER
	DATE	ACCTG PERIOD (MM/YY)	

I/3 VENDOR CUSTOMER NUMBER	AGENCY NAME Department of Human Services

VENDOR NAME AND ADDRESS	BILL TO ADDRESS (ORDERING AGENCY) Department of Human Services	SHIP TO ADDRESS

TERMS	FOB	ORDER APPROVED BY	CLAIM PREPARED BY
QUANTITY	VENDOR'S INVOICE DATE	VENDOR'S INVOICE NUMBER	

ORDERED	RECEIVED	UNIT OF MEASURE	DESCRIPTION	UNIT PRICE	TOTAL PRICE
EFT IND	YES ☐ NO ☐		Contract Number:		
				DOCUMENT TOTAL	

CLAIMANT'S CERTIFICATION

I CERTIFY THAT THE ITEMS FOR WHICH PAYMENT IS CLAIMED WERE FURNISHED FOR STATE BUSINESS UNDER THE AUTHORITY OF THE LAW AND THAT THE CHARGES ARE REASONABLE, PROPER, AND CORRECT, AND NO PART OF THIS CLAIM HAS BEEN PAID.

DATE **TITLE**

AGENCY CERTIFICATION

I CERTIFY THAT THE ABOVE EXPENSES WERE INCURRED AND THE AMOUNTS ARE CORRECT AND SHOULD BE PAID FROM THE FUNDS APPROPRIATED BY:

CODE OR CHAPTER SECTION(S)

CLAIMANT'S SIGNATURE

AUTHORIZED SIGNATURE

THE FOLLOWING FIELDS ARE FOR STATE ACCOUNTING USE ONLY

LINE	FUND	AGCY	UNIT	SUB UNIT	ACTV	RSRC	SUB RSRC	FUNC	OBJT	SUB OBJT	JOB NUMBER	REP CAT	QUANTITY / UNITS	I/D	DESCRIPTION	AMOUNT	I/D	P/F
01																		
02																		
03																		
04																		
05																		
06																		
07																		
08																		
09																		
10																		
11																		
12																		
13																		
14																		

DOCUMENT TOTAL

GAX (Rev. 11/10) WARRANT # AUDITED BY PAID DATE