NEW YORK STATE | Department of Health

Claim for Payment and BSROE

Extramural Grants Administration – Wadsworth Center

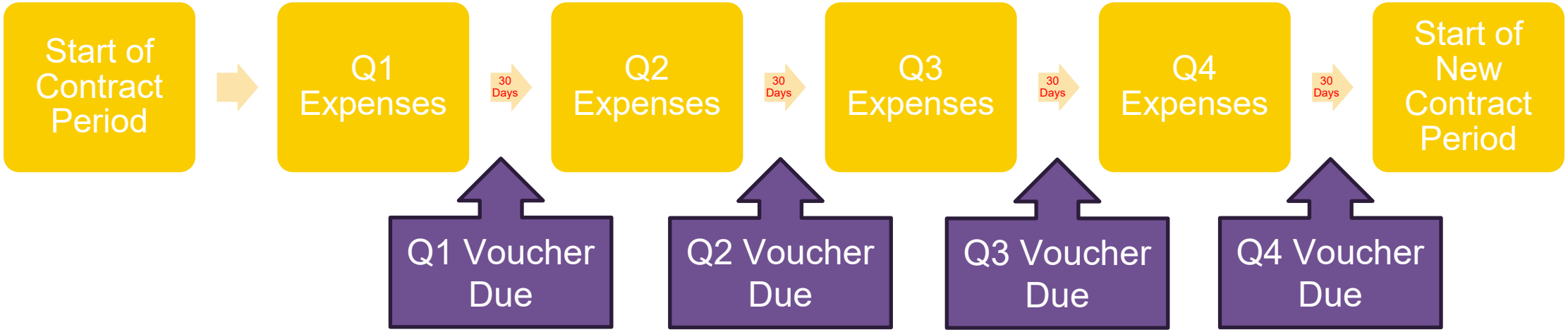
CLAIM FOR PAYMENT AND BSROE OVERVIEW

Claim for Payment	AC3253-S must be submitted with each reimbursement request
BSROE	The Budget Statement of Reported Expenses (BSROE) must be submitted with each AC3253-S

NEW YORK STATE | Department of Health

VOUCHERS AND BSROE OVERVIEW

- Use Claim for Payment form AC3253-S to report quarterly expenditures
- BSROE **must** accompany and support expenses
- Vouchers are due no later than 30 days after the end of a quarter and no later than 60 days after the end of the full Contract Term.



NEW YORK STATE | Department of Health

VOUCHERS AND BSROE OVERVIEW

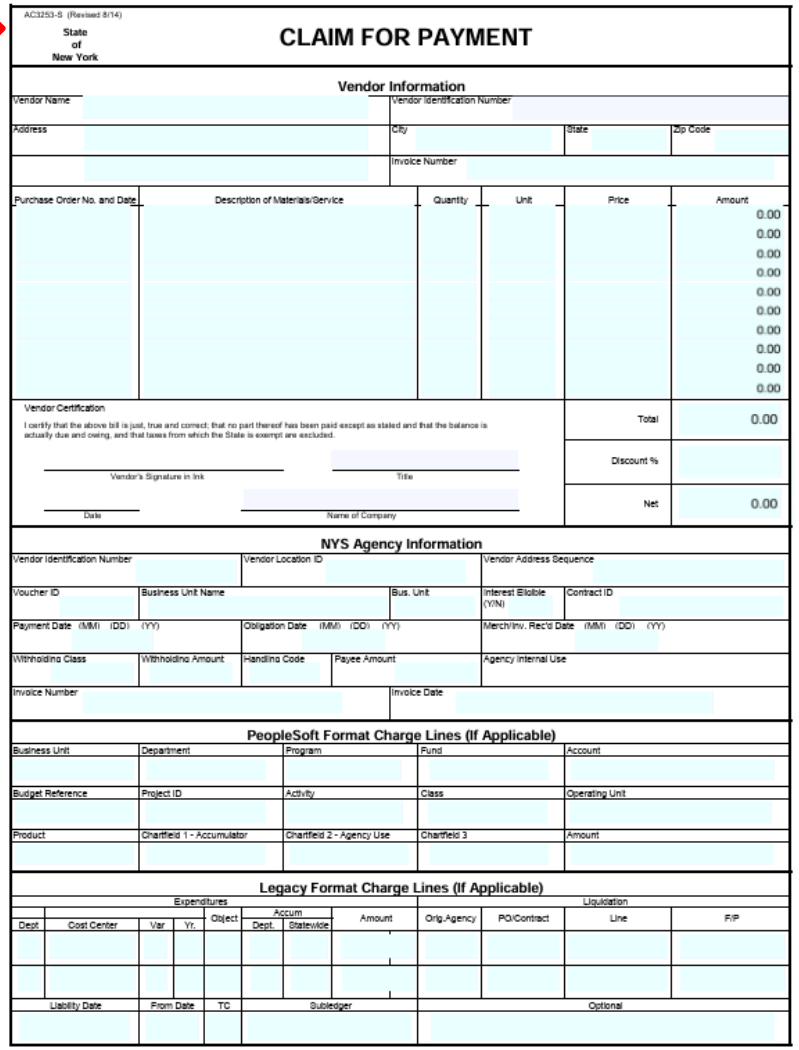
Common Voucher Mistakes

- Claim form missing signature
- BSROE missing
- Budget line(s) exceeded amount
- Incorrect Current Budget in Column I
- Mathematical Errors
- Not all funded items listed on BSROE, including Personal Service

NEW YORK STATE | Department of Health

CLAIM FOR PAYMENT FORM OVERVIEW

Confirm You Are Using the Correct Claim Form (AC3253-S)



AC3253-S (Revised 8/14)

State of New York

CLAIM FOR PAYMENT

Vendor Information

Vendor Name | Vendor Identification Number

Address | City | State | Zip Code

Invoice Number

Purchase Order No. and Date	Description of Materials/Service	Quantity	Unit	Price	Amount
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00

Vendor Certification

I certify that the above bill is just, true and correct; that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.

Vendor's Signature in Ink | Title

Date | Name of Company

Total 0.00

Discount %

Net 0.00

NYS Agency Information

Vendor Identification Number | Vendor Location ID | Vendor Address Sequence

Voucher ID | Business Unit Name | Bus. Unit | Interest Eligible (Y/N) | Contract ID

Payment Date (MM) (DD) (YY) | Obligation Date (MM) (DD) (YY) | Merch/Inv. Rec'd Date (MM) (DD) (YY)

Withholding Class | Withholding Amount | Handling Code | Payee Amount | Agency Internal Use

Invoice Number | Invoice Date

PeopleSoft Format Charge Lines (If Applicable)

Business Unit	Department	Program	Fund	Account
Budget Reference	**Project ID**	**Activity**	**Class**	**Operating Unit**
Product	**Chartfield 1 - Accumulator**	**Chartfield 2 - Agency Use**	**Chartfield 3**	**Amount**

Legacy Format Charge Lines (If Applicable)

Expenditures								Liquidation			
Dept.	Cost Center	Var	Yr.	Object	Accum Dept.	Accum Statewide	Amount	Orig.Agency	PO/Contract	Line	F/P

Liability Date	From Date	TC	Subledger	Optional

NEW YORK STATE | Department of Health

CLAIM FOR PAYMENT FORM SECTIONS 1-17

You Must Complete Sections 1-17

AC3253-S (Revised 8/14)

State of New York

CLAIM FOR PAYMENT

Vendor Information

Vendor Name (1)	Vendor Identification Number (2)		
Address (3)	City (4)	State (5)	Zip Code (6)
	Invoice Number (7)		

Purchase Order No. and Date (8)	Description of Materials/Service (9)	Quantity (10)	Unit (11)	Price (12)	Amount (13)

Vendor Certification (14)

I certify that the above bill is just, true and correct; that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.

Vendor's Signature in Ink _____ Title _____

Date _____ Name of Company _____

Total	(15)
Discount %	(16)
Net	(17)

Remember!
Use SFS Vendor ID Number, NOT FEIN

NEW YORK STATE | Department of Health

CLAIM FOR PAYMENT FORM INSTRUCTIONS

Reference	Name	New Length	Description
Vendor Information			
1	Vendor Name	40 AN	The vendor's name as it will appear on the check.
2	Vendor Identification Number	10 N	A unique identification number issued to the vendor by OSC. This is not the vendor's TIN or EIN. This field automatically populates if data is entered into the Vendor Identification Number field under the NYS Agency Information section of this form first.
3	Address	55 AN	Vendor's street address
4	City	30 AN	Name of the city in the vendor's address.
5	State	6 AN	Abbreviation of the name of the state in the vendor's address.
6	Zip Code	12 AN	Postal Code in the vendor's address.
7	Invoice No. (Limit to 13 Additional spaces)	30 AN	Invoice Number or special Reference number. This number will appear on check stub and should be unique. This field automatically populates if data is entered into the Invoice Number field under the NYS Agency Information section of this form first.
8	Purchase Order No. and Date	10 AN	The number of the encumbrance document and the date it was prepared.
9	Description of Materials/ Service	-----	Narrative describing the material purchased and/or services rendered; or, the vendor may attach an original invoice to the claim for payment.
10	Quantity	-------	The total number of each item purchased.
11	Unit	-------	The unit of measure for the items purchased.
12	Price	-------	The actual cost per unit if not attached.
13	Amount	-------	The total price per items, calculated by multiplying number of units by price per unit.
14	Payee Certification - Payee's Signature in Ink, Title, Date, Name of Company	--------	When a vendor's invoice is attached to the Claim for Payment, the 'Payee Certification ' does not need to be completed. If an invoice is not attached to the Claim for Payment, the signature of the payee or his authorized agent, his title, current date, and the name of the company is required.
15	Total	---------	The sum of the amount column. When Business Units use this form, they must ensure this field reconciles to the invoice amount.
16	Discount %	---------	(For vendor use only.) The discount percentage allowed by the vendor. This amount will be deducted from the Total (Reference 15) resulting in the Net (Reference 17).
17	Net	---------	(For vendor use only.) Total of document after discount has been deducted. This amount must equal the sum of either: 1) the merchandise amount(s) in the PeopleSoft format charge lines, or 2) the amount(s) in the Legacy format charge lines.

NEW YORK STATE | Department of Health

BSROE OVERVIEW

The revised BSROE form has been expanded to show expenses for the entire 12-month Contract Period, broken out among the four Claim Periods (a.k.a. Quarterly Vouchers). Each subsequent voucher submission should include the values claimed in the preceding quarter. See Slides 9-10 for additional details.

BUDGET STATEMENT AND REPORT OF EXPENDITURES

NYS DOH Wadsworth Center EGA

Genetics: genetic.counseling@health.ny.gov **HRSB:** HRSB@health.ny.gov **SCIRB** SCIRB@health.ny.gov	**Contract Number:**		**Contract Term:**	MM/DD/YY - MM/DD/YY
	Contractor SFS Payee Name:		**Contract Period:**	MM/DD/YY - MM/DD/YY
	Funding Source:		**Claim Period:**	MM/DD/YY - MM/DD/YY

0

CATEGORY OF EXPENSE	COLUMN I	COLUMN II	COLUMN III	COLUMN IV	COLUMN V	COLUMN VI
	CURRENT PERIOD APPROVED BUDGET	Quarter 1 Expenditures	Quarter 2 Expenditures	Quarter 3 Expenditures	Quarter 4 Expenditures	TOTAL EXPENDITURES THIS PERIOD TO DATE
1. PERSONAL SERVICES						

NEW YORK STATE | Department of Health

BSROE OVERVIEW – COMPLETING THE BSROE

Contract Term = Full Contract Term
Contract Period = 12 Month Budget Period
Claim Period = Quarter Being Vouchered

BUDGET STATEMENT AND REPORT OF EXPENDITURES

NYS DOH Wadsworth Center EGA

1 **Genetics:** genetic.counseling@health.ny.gov **HRSB:** HRSB@health.ny.gov **SCIRB** SCIRB@health.ny.gov	**Contract Number:**	C12345GM	**Contract Term:**	05/01/25-04/30/28
	Contractor SFS Payee Name:	The Research Organization	**Contract Period:**	05/01/25-04/30/25
	Funding Source:	SCRIB	**Claim Period:**	05/01/25-07/31/25

3 0 4 5

2 CATEGORY OF EXPENSE	COLUMN I	COLUMN II	COLUMN III	COLUMN IV	COLUMN V	COLUMN VI
	CURRENT PERIOD APPROVED BUDGET	Quarter 1 Expenditures	Quarter 2 Expenditures	Quarter 3 Expenditures	Quarter 4 Expenditures	TOTAL EXPENDITURES THIS PERIOD TO DATE
1. PERSONAL SERVICES						
a) SALARY	$ -	$ -	$ -	$ -	$ -	$ -
Principal Investigator - Dr. John Doe						-
Research Assistant - Jane Doe						-

1. This section must be filled out completely
2. Under Category of Expenses – enter Names/Titles, Subcontracts, Equipment, etc. as listed in contract
3. Column I must reflect most recently approved Attachment B-1 or B-1(A)
4. In Columns II-V (Q1-Q4) enter corresponding quarterly expenditure
5. Column VI cannot exceed Column I or “Over Budget” error will appear

NEW YORK STATE | Department of Health

BSROE OVERVIEW – COMPLETING THE BSROE

BUDGET STATEMENT AND REPORT OF EXPENDITURES

NYS DOH Wadsworth Center EGA

Genetics: genetic.counseling@health.ny.gov **HRSB:** HRSB@health.ny.gov **SCIRB** SCIRB@health.ny.gov	**Contract Number:**	C12345GM	**Contract Term:**	05/01/25-04/30/28
	Contractor SFS Payee Name:	The Research Organization	**Contract Period:**	05/01/25-04/30/25
	Funding Source:	SCRIB	**Claim Period:**	05/01/25-07/31/25

OVER BUDGET

CATEGORY OF EXPENSE	COLUMN I CURRENT PERIOD APPROVED BUDGET	COLUMN II Quarter 1 Expenditures	COLUMN III Quarter 2 Expenditures	COLUMN IV Quarter 3 Expenditures	COLUMN V Quarter 4 Expenditures	COLUMN VI TOTAL EXPENDITURES THIS PERIOD TO DATE
1. PERSONAL SERVICES						
a) SALARY	$ 85,000.00	$ 21,250.00	$ 12,500.00	$ 35,000.00	$ 20,000.00	OVER BUDGET
Principal Investigator (Name)	50,000.00	12,500.00	12,500.00	10,000.00	15,000.00	50,000.00
Research Scientist 1 (Name)	35,000.00	8,750.00	-	25,000.00	5,000.00	OVER BUDGET
Enter Position Title From Contract						-

Total Expenditures cannot exceed Approved Budget on ANY line or "Over Budget" error will appear

If "Over Budget", do NOT submit the BSROE.
A budget modification may be needed.

NEW YORK STATE | Department of Health

“Stop-the-Clock”

- Prompt payment legislation: 30 days from the date voucher is received
- Letter set to Fiscal Officer (cc: PI and Grants Official) stops the interest clock when:
  - Claim Form or BSROE is incorrect, missing or incomplete
  - Corresponding Progress Report is overdue, incorrect or incomplete
  - Scientific protocol approval submissions or Intellectual Property reports are not up to date
  - Voucher is selected for internal or external audit

Voucher will not be paid until the issue(s) is/are resolved

NEW YORK STATE | Department of Health

Any Questions?

Contact us at:

hrsb@health.ny.gov
scirb@health.ny.gov

or

(518) 474-7002

NEW YORK STATE | Department of Health

Department of Health