



California Department of Social Services
 744 P Street, MS 19-51
 Sacramento CA, 95814

PURCHASE/EXPENSE REQUEST APPROVAL FORM

Organization:	EXPENSE PERIOD: <input type="checkbox"/> OCT - DEC <input type="checkbox"/> APR - JUN <input type="checkbox"/> JAN - MAR <input type="checkbox"/> JUL - SEP
Name:	
Address:	
City, State, Zip Code:	
Phone Number:	

EXPENSE/PURCHASE INFORMATION:

Expense or Item Description	Amount

JUSTIFICATION/REASON FOR EXPENSE:

ORGANIZATION REPRESENTATIVE CERTIFICATION:

I certify that this purchase will be in accordance with 2 CFR 230 – Cost Principles for Non-Profit Organizations, the MOU and/or contract between the California Department of Social Services, good business practices, and other State and Federal rules and regulations. The related records to support the purchase will be on file and accessible to State and Federal agencies for at least three years, plus the current.

Signature of Authorized Representative	Date
Print or Type Name and Title of Authorized Representative	

FOR CDSS USE ONLY – REVIEW DECISION

APPROVED NOT APPROVED

CDSS Representative Signature: _____ Date _____

Comments: _____
