

REQUEST FOR REIMBURSEMENT OF EXPENSES

A summary of expenses must be submitted with this form.

CDSS USE ONLY	
FISCAL YEAR:	CONTRACT #:
PCA:	P.L.96-92:

1. ORGANIZATION:		2. COUNTY:	
3. ADDRESS: (NUMBER, STREET)		(CITY, STATE, ZIP CODE)	
4. TELEPHONE: ()	5. PROGRAM:	5. EXPENSES PERIOD:	

6. DATE/MONTH PAID	7. PAID TO	8. PURPOSE	9. AMOUNT
TOTAL THIS PAGE ONLY			

<p>11. I certify that the amounts requested above are for expenses that have not been previously reimbursed and that were incurred pursuant to an executed contract between the California Department of Social Services (CDSS) and this organization. I understand that any unliquidated cash advance will be deducted from this request in accordance with the CDSS policy. I declare under the penalty of perjury under the laws of the State of California that the foregoing is true and correct at the date of this signature.</p>	10. TOTAL QUARTERLY EXPENSES	
	CDSS USE ONLY	
	ADJUSTMENT	
	ADJUSTMENT	
	SUBTOTAL	
	LESS CASH ADVANCE	
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE	AMOUNT TO BE PAID
PRINT OR TYPE NAME AND TITLE OF AUTHORIZED REPRESENTATIVE		REMAINING UNLIQUIDATED CASH ADVANCE

CDSS USE ONLY	
REVIEWED BY:	DATE:
APPROVED BY:	DATE:
DATA POSTED TO ACCOUNT RECORD BY:	DATE:

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DATE/MONTH PAID	PAID TO	PURPOSE	AMOUNT

**TOTAL THIS PAGE ONLY:
(TO BE INCLUDED IN PAGE 1
TOTAL REQUESTED)**

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