REQUEST FOR REIMBURSEMENT OF EXPENSES

CDSS USE ONLY	
FISCAL YEAR:	Agreement #:
Service Location	P.L.96-92:

A summary of expenses must be submitted with this form.

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

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

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 agreement 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.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE
PRINT OR TYPE NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	

CDSS USE ONLY	
ADJUSTMENT	
ADJUSTMENT	
SUBTOTAL	
LESS CASH ADVANCE	
AMOUNT TO BE PAID	
REMAINING UNLIQUIDATED CASH ADVANCE	

CDSS USE ONLY		
PEER REVIEWED BY:	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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