Department of Health and Human Services

Division of Welfare and Supportive Services

Section D

FY19 Financial Status Report and Request for Funds

REQUEST FOR REIMBURSEMENT

Agency Ref # CC1905
Budget Account: 3267
GL: 20
Draw #:
CFDA # 93575

Program Name:	**Subrecipient's Name:**
Child Care Licensing Division of Welfare and Supportive Services	Washoe County Human Services Agency Child Care Licensing
Address:	**Address:**
1470 College Parkway Carson City, Nevada 89706-7924	P.O. Box 11130 Reno, NV 89520-0027
Subaward Period:	**Subrecipient's:**
July 01, 2018 through June 30, 2019	**EIN:** *****0138 **Vendor #:** T40283400

FINANCIAL REPORT AND REQUEST FOR FUNDS

(must be accompanied by expenditure report/back-up)

Month(s): _____ **Calendar year:** _____

Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year to Date Total	E Budget Balance	F Percent Expended
1 Personnel	$279,435.00	$0.00	$0.00	$0.00	$279,435.00	0.0%
2 Travel/Training	$0.00	$0.00	$0.00	$0.00	$0.00	-
3 Supplies/Operating	$5,000.00	$0.00	$0.00	$0.00	$5,000.00	0.0%
4 Equipment	$0.00	$0.00	$0.00	$0.00	$0.00	-
5 Contract/Consultant	$25,000.00	$0.00	$0.00	$0.00	$25,000.00	0.0%
6 Other	$0.00	$0.00	$0.00	$0.00	$0.00	-
7 Administrative / Indirect Costs	$15,472.00	$0.00	$0.00	$0.00	$15,472.00	0.0%
Total	**$324,907.00**	**$0.00**	**$0.00**	$0.00	$324,907.00	**0.0%**

I, a duty authorized signatory for the applicant, certify to the best of my knowledge and belief that this report is true, complete and accurate; that the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the grant award; and that them amount of this request is not in excess of current needs or, cumulatively for the grant term, in excess of the total approved grant award. I am aware that any false, fictitious or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims, or otherwise. I verify that the cost allocation and backup documentation attached is correct.

Authorized Signature Title Date

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Program contact necessary? _____ Yes _____ No Contact Person: _____

Reason for contact: _____

Scope of Work/approval date: _____ Signed: _____

Fiscal Review/approval date: _____ Signed: _____

□ Report Number/Unduplicated RFF
□ Prior Balances Match Contract Log
□ Math Accurate/Rff Trans Match
□ Travel Claim/Backup Doc Attached
□ No Negative Balances
□ Expenses Categorized per Budget
□ RFF Tracking Log
□ Subgrant Log
□ Approved in AF
□ To Fiscal
□ Expenses Allowable/Reasonable
□ Signed and Dated
□ Submitted through AF
□ Expenses in AF match RFF