

Agency Ref. #: **90.404-C016**Appr Unit: **105119**GL: **8516**Job Number: **9040420C**

ADV Desc: _____

SECTION D**Request for Reimbursement**

Program Name: FFY2020 HAVA CARES Act Jacob Roberts jjroberts@sos.nv.gov 775-684-7195	Subrecipient Name: Deanna Spikula dspikula@washoecounty.us 775-328-3674
Address: 101 N. Carson Street, Suite 3 Carson City, NV 89701	Address: 1001 E 9 th St., Bldg. A, Rm 135 Reno, NV 89512
Subaward Period: 3/23/2020 – 12/01/2020	Subrecipient's: EIN: 88-600138 Vendor #: T40283400

FINANCIAL REPORT AND REQUEST FOR REIMBURSEMENT

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

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. Voting Processes	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
2. Staffing	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
3. Security & Training	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
4. Communications	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
5. Supplies	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-

MATCH REPORTING	Approved Match Budget	Total Prior Reported Match	Current Match Reported	Year to Date Total	Match Balance	Percent Completed
INSERT MONTH/QUARTER	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-

I, a duly 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 the 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 _____

FOR Department USE ONLY

Is program contact required? ____ Yes ____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____

Scope of Work review/approval date: _____

Chief (as required): _____ Date _____