State of California
Department of Mental Health

808.01 Attachment I

GRANT FINANCIAL STATUS REPORT
MH 1784 (04/04)

INSTRUCTIONS ARE ON THE REVERSE SIDE. STATE FISCAL YEAR _____

COUNTY _____ I.D.# (IF APPLICABLE) _____

TYPE OF GRANT (Check One Only): SAMHSA _____ PATH _____

SUBMISSION (Check One): _____ FIRST _____ SECOND _____ THIRD _____ FOURTH _____ COST REPORT

A. Grantee Information:

1. Name of Contact Person: _____
2. Address: _____ Unit: _____

   City and Zip Code: _____ E-Mail Address: _____ Telephone: _____
3. Accounting Basis: _____ Cash _____ Accrual _____ Modified Accrual

B. Provider Information: (Attach separate list if more than one provider)

1. Provider: _____
2. Address: _____

   City and Zip:_____
3. Employer Identification Number (If Applicable): _____

C. Fiscal Information Related to COUNTY (Not by Provider) Operations of the Grant:

1.	Net expenditures previously reported (line C.3. from prior quarters report)	$_____
2.	2 Total net expenditures this report period (worksheet on back)	$_____
3.	Net expenditures to date (line C.1. plus line C.2.)	$_____
4.	Less: Nongrant share of expenditures	$_____
5.	Total grant share of expenditures (line C.3. minus C.4.)	$_____
6.	Total unliquidated obligations	$_____
7.	Less: Nongrant share of unliquidated obligations	$_____
8.	Grant share of unliquidated obligations (line C.6. minus line C.7.)	$_____
9.	Total grant share of expenditures and unliquidated obligations (line C.5. plus line C.8.)	$_____
10.	Total amount of grant funds authorized	$_____
11.	Unobligated balance of grant funds (line C.10 minus line C.9.)	$_____

D. Nonfiscal Information:

1. Certification: I certify, to the best of my knowledge and belief, under penalty of perjury, that this report is correct and complete and that all disbursements have been made in accordance with the grant agreement.
2. Signature:_____ Date: _____
3. Name and Title: (Print or Type) _____
4. Telephone Number: (_____)_____ Extensions: _____

E. Remarks: _____