ATTACHMENT #4

COUNTYWIDE ACTIVITY FUND (CAF) CLAIM FORM

Name:Address:		Which Service Area do you live in?			
		City:	State:	Zip Code:	
hone	Number:	Vendor I.D.:			
Mee	tings for the Month of:				
1	Name of Meeting:		Date:	Time:	
-	Address:	City:	State:	Zip Code:	
	Name of Facilitator/Coordinator		Signature	Date	
2	Name of Meeting:		Date:	Time:	
	Address:	City:	State:	Zip Code:	
	Name of Facilitator/Coordinator		Signature	Date	
3	Name of Meeting:		Date:	Time:	
	Address:	City:	State:	Zip Code:	
	Name of Facilitator/Coordinator		Signature	Date	
pplicant Signature:		Date:			
MH Service Area Liaison Signature:			Date:		

All monthly CAF claim forms must be submitted to the DMH Service Area Liaison for review and approval who will in turn submit to MHSA Administration for approval and payment processing. Please note, MHSA Administration will not accept ANY claims that have not been approved and submitted by the DMH Service Area Liaison.

Please contact CAF@dmh.lacounty.gov for any questions or inquires