LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH

MHSA ADMINISTRATION & OVERSIGHT DIVISION

ATTACHMENT #4

COUNTYWIDE ACTIVITY FUND (CAF) CLAIM FORM

Name:_____ Which **Service Area** do you live in? _____

Address:_____ City: _____ State: _____ Zip Code: _____

Phone Number:_____ **Vendor I.D.:** _____

Meetings 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**

Applicant Signature: _____ **Date:**_____

DMH 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