Department of Health and Human Services
Aging and Disability Services (ADSD)

Agency Ref #
Budget Account:
GL:
Draw #: 1
CFDA #

Financial Status Report and Request for Reimbursement

Program Name:	Subrecipient Name:
ADSD PAC Unit, Grants Management	
Program Address:	**Subrecipient Address:**
3416 Goni Road, #D-132, Carson City, NV 89706	
Subaward Period:	**Subrecipient's:** EIN: Vendor #:

FINANCIAL REPORT AND REQUEST FOR REIMBURSEMENT

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

Month(s):
Calendar Year:

☐ ORIGINAL REQUEST ☐ REVISED REQUEST

☐ ADVANCE ☐ REIMBURSEMENT

		A	B	C	D	E	F
	Approved Budget Category	Approved Budget	Total Prior Requests	Current Request	Year to Date Total	Budget Balance	Percent Requested
1	Personnel		$0.00		$0.00	$0.00	-
2	Travel		$0.00		$0.00	$0.00	-
3	Operating		$0.00		$0.00	$0.00	-
4	Equipment		$0.00		$0.00	$0.00	-
5	Contract/Consultant		$0.00		$0.00	$0.00	-
6	Training		$0.00		$0.00	$0.00	-
7	Other		$0.00		$0.00	$0.00	-
8	Indirect Costs/ Admin Expenses		$0.00		$0.00	$0.00	-
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	-

Additional Financial Reporting - All Award Types

	Budget Item	Required Amount	Total Prior Months	Current Amount	Year to Date Total	Budget Balance	Percent Provided
1	Match		$0.00		$0.00	$0.00	-

☐ N/A

Advance Payment Reconciliation

Budget Categories or Specific Components (Expand rows as needed)	Month: Received	Expended	Total Funds to Date: Funds Advanced	Expended	Balance	Percent Expended
			$0.00	$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 subaward; and that the amount of this request is not in excess of current needs or, cumulatively for the award term, in excess of the total approved subaward. 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 are 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: _____

Year-to-Date Report - Requested Reimbursement

Program Name

		Budget	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Y-T-D	% expended	Balance
SECTION I			8%	17%	25%	33%	42%	50%	58%	67%	75%	83%	92%	100%			
Personnel		-	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
Travel		-	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
Operations		-	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
Equipment		-	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
Contractual/Consultant		-	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
Training		-	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
Other		-	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
Indirect		-	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
SECTION I - Total:		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-	#DIV/0!	-
SECTION II			8%	17%	25%	33%	42%	50%	58%	67%	75%	83%	92%	100%			
Personnel:	First & Last Name: FTE	Request %															
															-	#DIV/0!	
															-	#DIV/0!	
															-	#DIV/0!	
															-	#DIV/0!	
															-	#DIV/0!	
															-	#DIV/0!	
Total:			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
Fringe:																	
FICA															-	#DIV/0!	
Worker's Comp															-	#DIV/0!	
Unemployment Ins															-	#DIV/0!	
Retirement															-	#DIV/0!	
Group Insurance															-	#DIV/0!	
															-	#DIV/0!	
Total:			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	
TOTAL PERSONNEL:			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-
Travel:																	
															-	#DIV/0!	
															-	#DIV/0!	
TOTAL TRAVEL/TRAIN:			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-
Operating:																	
															-	#DIV/0!	
															-	#DIV/0!	
															-	#DIV/0!	
TOTAL OPERATING			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-
Equipment:																	
															-	#DIV/0!	
															-	#DIV/0!	
															-	#DIV/0!	
TOTAL EQUIPMENT:			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-
Contractual:																	
															-	#DIV/0!	
															-	#DIV/0!	
															-	#DIV/0!	
TOTAL CONTRACTUAL:			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-
Training:																	
															-	#DIV/0!	
															-	#DIV/0!	
TOTAL Training:			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-
Other:																	
															-	#DIV/0!	
															-	#DIV/0!	
TOTAL OTHER:			-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-
Indirect:																	
															-	#DIV/0!	

Transaction List & Source Documentation* *with submission of this document, requester certifies they are maintaining all source documentation (2CFR200.302 (1-7))					Insert % charged to this RFR here.	Insert % of cost allocated to other funding sources in column G-I. Add more as necessary to show 100% cost allocation.					
Check Date	Check Number (ck/doc.)	Payee/ Vendor	Description of Expense	Total Cost	% Charged to (Name of Funding) funding source	% Charged to (Name of Funding) funding source	% Charged to (Name of Funding) funding source	% Charged to (Name of Funding) funding source	Total Cost Allocation (must equal 100%)	Amount Charged to Grant	Match Amount Assigned to Grant
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
			Total Personnel	$0.00						$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
			Total Travel/Training	$0.00						$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
			Total Operating	$0.00						$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
			Total Equipment	$0.00						$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
			Total Contractual/Consultant	$0.00						$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
				$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
			Total Other	$0.00						$0.00	$0.00
		Indirect	??% of total cost	$0.00	0.00%	0.00%	0.00%	0.00%	0.00%	$0.00	$0.00
			Total Indirect	$0.00						$0.00	$0.00
									Total Requested	$0.00	$0.00

Training Summary

Name of Staff	Brief Description (e.g., name of training, location, etc.)	Date(s) of Training-Related Travel	Other Expense (e.g., Registration)	Amount
		Total:		$ -

TRAVEL EXPENSE REIMBURSEMENT CLAIM

(SEE STATE ADMINISTRATIVE MANUAL 0200 FOR TRAVEL REGULATIONS)

Traveler Name: _____

Address: _____

_____

Program Name: _____

Official Duty Station (City): _____

I declare under penalties of perjury that to the best of my knowledge this is a true and correct claim in conformance with the governing statutes and the State Administrative Manual and its updates.

X I do **not** have a travel advance

_____ I **do** have a travel advance from my agency or State Treasurer

_____

Signature of Traveler

(Do not sign in black ink)

_____

Program Approval (REQUIRED)

Transportation Codes:

P - Plane
PP - Private Plane
PC - Private Car
OT - Other*: Taxi, Shuttle, Rental Car, Inter-City Bus or Rail
X - Passenger in Car
PT - Public Trans: Subway, City Bus
SC - State Car: Motor Pool or Agency Car

Miscellaneous Codes:

A - ATM Fees*
OT - Other*: Airport Parking
I - Incidental Expense

Traveler is:

_____ Organization Employee
_____ Board or Commission Member
X Subrecipient Contract Provides for Travel

Date(s) of travel	Destination and Purpose of Travel (Include to/From and reason)	Travel Times		Transportation			Misc. Expenses		Daily Expenses				Total
									Meals			Lodging*	
		Started	Ended	Code	Mileage	Cost	Code	Cost	B	L	D		
*** Remember to indicate the location for the travel / training.**													
													0.00
													0.00
													0.00
													0.00
													0.00
													0.00
													0.00
													0.00
													0.00
													0.00
													0.00
													0.00
				Totals:	0.00		0.00		0.00	0.00	0.00	0.00	
Total of this Claim													$ -
Less Travel Advance Received from the Traveler's Agency or Agency Credit Card:													-
Balance Due to Traveler:													$ -

***Receipts are required for:** All "Other" expenses, ATM Fees, Lodging, all out-of-state lodging and transportation expenses.

Traveler is personally liable for repaying advances and Travel Card charges.

Meal times:
Breakfast if departure is at or prior to 7:00am
Lunch if departure is at or prior to 11:30am and return after 1:00pm
Dinner if departure at or prior to 6:00pm and return after 7:00pm

Department of Health and Human Services

Division #
Bureau Program #

IN-KIND CONTRIBUTION / MATCH

Program Name:	Subgrantee Name:
#REF!	#REF!
Subgrant Period:	**Address:**

FINANCIAL REPORT FOR MATCHING

Total Amount Awarded. $ 0

Match Percentage 0%

Total Required Match $ 0

	Approved Budget Category	Reported Match
1	Personnel	$ -
2	Travel	$ -
3	Operating	$ -
4	Contract/Consultant	$ -
5	Supplies	$ -
6	Indirect	$ -
7	Other	$ -
8	**Total**	$ -

	Match
Jul	$ -
Aug	$ -
Sept	$ -
Oct	$ -
Nov	$ -
Dec	$ -
Jan	$ -
Feb	$ -
Mar	$ -
Apr	$ -
May	$ -
June	$ -
YTD Total	$ -

*** Must be accompanied by Transaction List/Source Documentation and Year-to-Date Report**

This report is true and correct to the best of my knowledge.

Authorized Sub-Recipient Signature Title Date

Reminder: Match reporting must also be included in the Transaction List/Source Documentation tab. Other federal funding cannot be used to provide any part of the required match. Match requirements must be met as outlined in award. Please ensure maintenance of fiscal breakout details such as volunteer sign-in sheets and calculation of hours worked x cost per hour.

Request to Modify and/or Redirect Budget

Agency Ref #: #REF!
Budget Account: #REF!
GL: #REF!
CFDA #: #REF!

Program Name:	Subrecipient Name:
#REF!	#REF!
Address:	**Address:**
#REF!	#REF!
Subgrant Period:	**Subrecipient's:**
#REF!	EIN: #REF!
	Vendor #: #REF!

COST CATEGORY	ORIGINAL AWARDED	REQUESTED REDIRECTION	NEW/REVISED BUDGET	JUSTIFICATION	IDENTIFY GOAL AND OBJECTIVE FUNDING REDIRECT ALIGNS WITH
Salaries and Wages			$0		
Fringe Benefits			$0		
Personnel Costs (Subtotal)	$0	$0	$0		
Travel Costs			$0		
Operating			$0		
Equipment			$0		
Contract/Consultant			$0		
Other			$0		
Total Direct Costs	$0	$0	$0		
Indirect Costs			$0		
Total Award	$0	$0	$0		

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 te dut 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 ondit 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: _____