ATTACHMENT B-1 Mental Health Student Services Act of 2019 (MHSSA) GRANT AWARD CLAIM FORM

To: Mental Health Services Oversight and Accountability Commission 1325 J Street, Suite 1700 Sacramento, CA 95814 Attn: Accounting Office					Check One Year 1 Year 2 Year 3 Year 4 Year 4	Check One Quarter 1 Quarter 2 Quarter 3 Quarter 4 Quarter 4	
From:				Contract N	NO.		
Mailing Address:							
	Costs	A Budget Amount	B Beginning Balance	C Adjustments	D Current Expense	Ending Balance	
	Personnel						
	Administration						
Total Allowable Costs \$							
MHSOAC USE ONLY					FOR GRANTEE'S USE –Use blue ink		
I hereby certify that all services and required reports have been				I CERTIFY that I am a duly appointed and acting officer of the herein named county/lead agency: that the costs being			
received pursuant to the contract/grant.				claimed are in all respects true, correct, and in accordance			
				with the grant provisions, and that the funds were expended or obligated during the project year.			
X Signature Program Coordinator DATE							
				X	X Signature of Mental Health/Behavioral DATE		
				Health Director or designee/Grant Lead			
Name of Signatory				Name of Sigr	Name of Signatory		
				Title	Title		
FOR MHSOAC ACCOUNTING USE ONLY					GRANTEE'S CONTACT INFORMATION		
SFY: FY 2019-20 □							
			FY 2020-21		Contact Deverse (Deit 1)		
Grant Title: MHSOAC MHSSA Grant MHSA Grant			FY 2021-22 □ FY 2022-23 □	Contact Person (Print)			
Award:							
PCA: 30118 INDEX: 5500 OBJECT CODE: 5432000					Phone		