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 ☐	**Check One** Quarter 1 ☐ Quarter 2 ☐ Quarter 3 ☐ Quarter 4 ☐

From: _____ **Contract No.** _____

Mailing Address: _____

_____

_____

Costs	A	B	C	D	
	Budget Amount	**Beginning Balance**	**Adjustments**	**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 received pursuant to the contract/grant. X_____ Signature Program Coordinator DATE _____ Name of Signatory	I CERTIFY that I am a duly appointed and acting officer of the herein named county/lead agency: that the costs being 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 of Mental Health/Behavioral Health Director or designee/Grant Lead DATE _____ Name of Signatory _____ Title

FOR MHSOAC ACCOUNTING USE ONLY		**GRANTEE'S CONTACT INFORMATION**
SFY:_____ **Grant Title:** MHSOAC MHSSA Grant **MHSA Grant Award:**_____ **PCA:** 30118 **INDEX:** 5500 **OBJECT CODE:** 5432000	FY 2019-20 ☐ FY 2020-21 ☐ FY 2021-22 ☐ FY 2022-23 ☐	_____ Contact Person (Print) _____ Phone