

GRANT CASH TRANSACTION REPORT
MH 1785 (04/04)

INSTRUCTIONS ARE ON THE REVERSE SIDE.

STATE FISCAL YEAR _____

COUNTY _____

I.D.# (IF APPLICABLE) _____

TYPE OF GRANT (Check One Only): SAMHSA _____ PATH _____

SUBMISSION (Check One): _____ FIRST _____ SECOND _____ THIRD _____ FOURTH _____ COST REPORT

A. Grantee Information:

1. Name of Contact Person: _____
2. Address: _____ Unit: _____
City and Zip Code: _____ E-Mail Address: _____ Telephone: _____

B. Provider Information: (Attach separate list if more than one provider)

1. Provider: _____
2. Address: _____
City and Zip: _____
3. Employer Identification Number (If Applicable): _____

C. Fiscal Information Related to COUNTY (Not by Provider) Operations of the Grant:

- | | | |
|---|----------|----------|
| 1. Cash on hand beginning of period (from line 6 prior qtr. report): | | \$ _____ |
| 2. Receipts: | | |
| A. Reimbursements | \$ _____ | |
| B. Advances | \$ _____ | |
| C. Grant Share of Income | \$ _____ | |
| D. Interest Income | \$ _____ | |
| | Total | \$ _____ |
| 3. Total Cash Available (sum of line C.1. and C.2.): | | \$ _____ |
| 4. Disbursements: (insert as a negative number) | | \$ _____ |
| 5. Adjustments of prior quarters: (insert as negative or positive number, as appropriate) | | \$ _____ |
| 6. Cash on hand at end of quarter: | | \$ _____ |
| 7. The amount shown on line 6. represents cash requirements for the next _____ days (should not exceed 3 days). | | |
| 8. Advances during the quarter: All Providers | | \$ _____ |

D. Nonfiscal Information:

1. Certification: I certify, to the best of my knowledge and belief, under penalty of perjury, that this report is correct and complete and that all disbursements have been made in accordance with the grant agreement.
2. Signature: _____ Date: _____
3. Name and Title: (Print or Type) _____
4. Telephone Number: (____) _____ Extension: _____

E. Remarks: _____