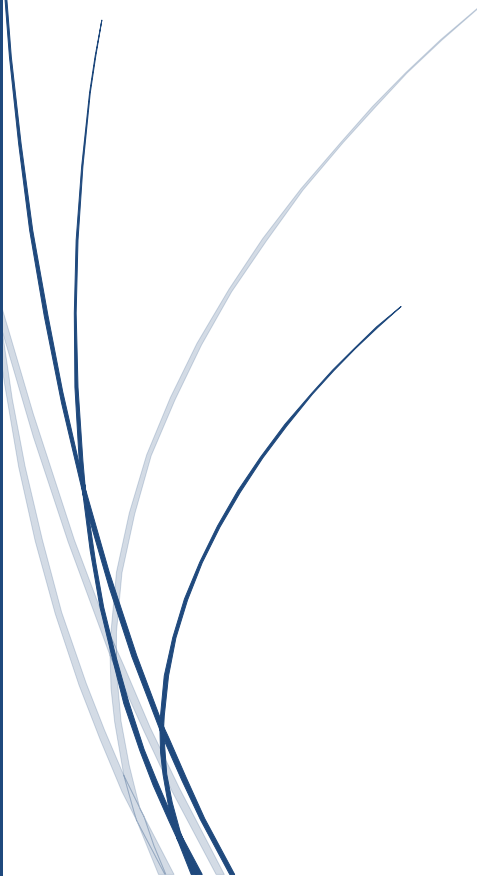




5/2/2023

FINANCIAL GUIDELINES FOR AMERICAN RESCUE PLAN FOR DOMESTIC VIOLENCE SHELTER AND SUPPORTIVE SERVICES PROJECT



Guidance for Budgets and Modifications,
Invoices, and Financial Closeout Reports

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC
HEALTH, OFFICE OF WOMEN'S HEALTH

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INTRODUCTION

The American Rescue Plan Act (ARP) funding is to assist Domestic Violence (DV) service providers by covering necessary expenses incurred to respond to or address the economic harm resulting from or exacerbated by the COVID-19 public health emergency.

The purpose of these instructions is to provide guidance and procedures on how to properly complete the ARP budget, budget modification, invoice, and closeout report forms.

ARP budget, budget modification, invoice/supplemental invoice, and financial closeout report forms are located at:

<http://publichealth.lacounty.gov/owh/OWHContracts/ARP/ARP.htm>

ALLOWABLE COSTS

The allowable costs include those expenses that are NOT funded under another funding source for clients served under these agreements. Allowable costs include salaries and employee benefits for direct staff providing services hereunder (Case Management, Mental Health/Counseling, Legal, and Childcare Services). Additionally, the following costs are reimbursable as long as those costs are not reimbursed under another funding source:

- **Childcare Service Expenditure**
Services that are provided by a licensed childcare provider. Childcare does not include services that an agency provides for clients when seeking services at their location when agency staff provide oversight of a client's child.
- **Necessities of Life Assistance**
Distribution of vouchers and gift cards shall not exceed \$500 per client plus an additional \$125 per family member served under this agreement, not to exceed \$1,000 per family per year.

Subrecipients shall purchase gift cards by May 2024. No gift cards shall be purchased in June 2024 or later. Subrecipients may only purchase gift cards in the amounts they anticipate on distributing each month. Gift cards shall be reimbursed as they are distributed to each client, not as they are purchased from subrecipient vendors.

Alcohol and tobacco products are not allowed under this agreement. The agency should have a protocol in place to inform the clients that they should not use the gift cards for unallowable items.

- **Emergency Housing/Hotel Shelter Services**
The rate of contractor reimbursement for hotel/motel is \$160.00 per night and each additional family member is \$35.00 per night plus taxes. Clients are limited to a maximum stay of 60 nights total per year for hotel shelter nights.
- **Client Personal Protective Equipment (PPE)**
PPE including expenses for purchasing and distribution of medical and protective supplies (e.g., sanitizing products and PPE for clients).

Treasury’s final rule, program guidance, and the Uniform Guidance outline the types of costs that are allowable, including certain audit costs. For example, per 2 CFR 200.425, a reasonably proportionate share of the costs of audits required by the Single Audit Act Amendments of 1996 are allowable; however, cost for audits that were not performed in accordance with 2 CFR Part 200, Subpart F and the Compliance Supplement are not allowable.

Recipients may use funds for administering the State and Local Fiscal Recovery Funds (SLFRF) program, including costs of consultants to support effective management and oversight, including consultation for ensuring compliance with legal regulatory, and other requirements. Further, costs must be reasonable and allocable as outlined in 2 CFR 200.404 and 2 CFR 200.405. Pursuant to SLFRF Award Terms and Conditions, recipients are permitted to charge both direct and indirect costs to their SLFRF award as administrative costs as long as they are accorded consistent treatment per 2 CFR 200.403. Direct costs are those that are identified specifically as costs of implementing the SLFRF program objectives, such as contract support, materials, and supplies for a project. Indirect costs are general overhead costs of an organization where a portion of such costs are allowable to the SLFRF award such as the cost of facilities or administrative functions like a director’s office. Each category of cost should be treated consistently in like circumstances as direct or indirect, and recipients may not charge the same administrative costs to both direct and indirect cost categories, or to other programs.

BUDGET

Completion of the budget and justification forms is a contractual requirement of all agreements with the Office of Women’s Health. You must provide clear and complete justification for all proposed costs at the level of detail requested in these instructions or the budget(s) and budget modifications will be returned to your agency for corrections and resubmission. It is highly recommended that you assess the validity and thoroughness of your overall budget prior to submission to OWH to avoid the back-and-forth resubmissions that would occur due to missing or incomplete information.

The following documents are required to submit with the budget form:

- Cost Allocation Plan: if the budget includes shared program expenditures such as rent, utilities, telephone, ...etc.

- Lease Agreement: if the budget includes rent.
- Approved Negotiated Indirect Costs Rate Agreement (NICRA): if the indirect cost rate is higher than 10% of direct cost.
- Agency's Internal Approved Mileage: if the budget includes mileage, please indicate your agency's mileage rate (the rate that your agency reimburses all employees for mileage). Please note that DPH cannot reimburse mileage more than the County's mileage reimbursement rate, which is 61.5 cents per mile, effective 1/1/2023.

Please submit the budget form (includes justification) and required documents to OWH Finance inbox at: OWHFinance@ph.lacounty.gov with the subject line: (AGENCY NAME) ARP Budget FY 20xx-xx.

Salaries

List employee name, payroll title, number of months, monthly salary, and % time FTE for providing above services to eligible clients. Please ensure that there are no staff who's combined Full-Time Equivalents (FTE) percentages across all funding sources exceeds 100%. For example, Domestic Violence Supportive Services Program (DVSS), Domestic Violence Shelter Based Program (DVSBP), ARP and Others. Please ensure that staff funded under other funding sources are not charged to budgets under these agreements.

The budget request will be automatically calculated based on the data entered.

Please input the amount of each line item in the Supervisorial District (SD) column(s) based on your agency's allocation.

Employee Name	Payroll Title	Number Of Months	Monthly Salary	% Time FTE	Budget Request	Budget Allocation by Supervisorial District				
						1	2	3	4	5
					\$ -					
					-					
					-					
					-					
					-					
TOTAL SALARIES					0.00%	\$ -	\$ -	\$ -	\$ -	\$ -

Provide a narrative justification for each position by describing the staff's role related to ARP services.

Employee Name	Payroll Title	Narrative Justification Describe Staff's Role Related to Program Services	Budget Request
			-
			-
			-
			-
			-
			-
			-
			-
			-
Total Personnel Costs			\$ -

Employee Benefits

Enter the employee benefit percentages, and the budget request will be automatically calculated.

EMPLOYEE BENEFITS(EB)	Allocated %	Budget Request	1	2	3	4	5
FICA	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Social Security	0.00%	-	-	-	-	-	-
Retirement	0.00%	-	-	-	-	-	-
SUI	0.00%	-	-	-	-	-	-
Health Plan	0.00%	-	-	-	-	-	-
Worker's Compensation	0.00%	-	-	-	-	-	-
Long-Term Disability	0.00%	-	-	-	-	-	-
Life Insurance	0.00%	-	-	-	-	-	-
	0.00%	-	-	-	-	-	-
EMPLOYEE BENEFITS(EB)	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Operating Costs

Please enter:

- Operating cost items (hotel bed night, gift cards, client personal protective equipment, rent, utilities, telephone, etc.) that directly support ARP program activities as listed above.
- Amount requested for each line item.
- The amount of each line item in the SD column(s) based on your agency's allocation.

OPERATING COSTS	Budget Request	1	2	3	4	5
Service Description						
TOTAL OPERATING COSTS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Provide a detailed description for each line item, which includes sufficient information to clearly show how the costs were determined, including the methodology and calculations used to arrive at the requested amounts. OWH may request supporting documentation for verification during the contract budget negotiation period.

Service Description	Detailed Justification (List all items and provide detailed calculation in each budget line)	Budget Request
		-
		-
		-
		-
		-
		-
		-
		-
Total Operating Costs		\$ -

Examples for operating costs:

- **Office Supplies - \$1,246:** Agency's estimated cost for supplies is \$23,250. Cost allocated to this program is 5.36% (3 FTE/56 agency staff = 5.36%). $\$23,250 \times 5.36\% = \$1,246$. Includes cost of office supplies allocated to this program such as pencils, pens, paper, client files, stationery, envelopes, and fax paper with agency letterhead needed to support client services.
- **Facility Rent - \$25,800:** $\$2.00/\text{sq. ft.} \times 1,075 \text{ sq. ft.} \times 12 \text{ mos.} = \$25,800$. Program occupies 100% of the service space noted above for direct client services at service delivery site address.
- **Telephone - \$858:** Cost allocated to this program is 5.36% (3 FTE/56 agency staff = 5.36%). The agency's estimated cost is $\$16,000 \times 5.36\% = \858 for program telephone service to contact clients.
- **Hotel Shelter Bed Night - \$53,760:** Estimated cost based on price quotes. Anticipate provide hotel shelter bed night to domestic violence survivors for 300 nights (for 15 clients) $\times \$160.00$ per night = $\$48,000$ plus taxes $\$5,760$ (12% of $\$48,000$). Total requested amount will be $\$53,760$.
- **Client Personal Protective Equipment - \$1,095:** Estimated cost based on price quotes: Surgical Mask $\$15$ per box $\times 30 = \$450$; hand sanitizer $\$5$ per bottle $\times 40 = \$200$; Lysol Wipe $\$10$ per pack $\times 20 = \$200$; gloves at $\$35$ per box $\times 7 = \$245$ for clients to keep them safe.
- **Client's Necessity of Life Cards - \$50,000:** Estimated to provide grocery store gift cards to 100 domestic violence survivors at $\$500$ each who are in need of food assistance. Unallowable costs are alcohol and tobacco products.

Indirect Costs

If a contractor has a current NICRA established with a Federal cognizant agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals, then the contractor may use its current NICRA. If the contractor does not have a NICRA, the contractor may elect to use the de minimis rate of 10 percent of the modified total direct costs.

BUDGET MODIFICATION

To request a modification to your approved budget, contractors must submit a Budget Modification form (includes justification) and supporting documents (if applicable) to OWH Finance inbox at: OWHFinance@ph.lacounty.gov with the subject line: (AGENCY NAME) ARP Budget Modification FY 20xx-xx prior to billing for any new staffing or other costs indicated in the budget modification request.

The budget modification allows contractors to move budgeted dollars from one-line item to another line item within maximum contract amount.

Please note that the agency is allowed to request to shift funds from one SD to another on the budget modification under this agreement.

Contractors are allowed to submit budget modification requests once per quarter, and no later than **March 31st** of each fiscal year.

Budget Modification form includes budget worksheet and narrative justification that require contractor to list all funded items and provide detailed justification for the changes.

Salaries

The contractor must list all budget lines as they appear in the most recent approved budget including staff left the agency to ensure the current budget amounts in the budget modification match with the most recent approved budget. If there are any changes to the personnel within the maximum contract amount under this contract including vacant items, staff replacement, and additional staff, please list all items in the budget modification worksheet, and provide detailed justification by describing specific duties and responsibilities for each position on the narrative page.

Budget modification requests should be submitted as soon as the agency knows there are staffing changes in their ARP Programs. Please accurately indicate the amount of time a new staff person will work on the revised budget. The budget changes start from the time that the agency submits their budget modification, not prior months. For example, in December 2023, ABC Agency submitted a budget modification to increase their FTE from 20% to 50% for the Case Manager (Green Apples). Assuming that this grant period is for 7/1/23-6/30/24, there will be 2 budget lines for Green Apples: one line budgeted for 5 months (Jul-Nov) at 20% and another line budgeted for 7 months (Dec-Jun) at 50% and the current budget amount noted at the approved budgeted line item, then the second line showing zero dollars in current budget line-item amount. Please ensure that the budgeted amounts on the adjusted line items are not lower than the amounts that have been reimbursed.

Also, the agency hired a new Case Manager (Summer Brightly) who started working in December, or for 7 months of the contract term.

Employee Name	Payroll Title	Number Of Months	Monthly Salary	% Time FTE	Current Budget	Budget Changes	Budget Request
Green Apples	Case Manager	5	\$ 4,322	20.00%	\$ 10,373	\$ (6,051)	\$ 4,322
Green Apples	Case Manager	7	4,322	50.00%	-	15,127	15,127
Autumn Fall	Program Manager	12	10,647	10.00%	12,776	-	12,776
Bee Healthy	Therapist	12	8,540	25.00%	25,620	-	25,620
Summer Brightly	Case Manager	7	4,777	50.00%	-	16,720	16,720
Red Berries	DV Advocate	12	4,620	25.00%	13,860	-	13,860
						-	-
						-	-
						-	-

Budget Allocation by Supervisor District

Please input the amount of each line item in the SD column(s) based on your agency's budget request for each line item. This example shows that the agency is funded in two supervisorial districts. The green box at the end is for verification only. The total for each line item should match the budget request line items. If not, there will be a variance, which would need to be corrected. Variance should equal zero.

Budget Request	Budget Allocation by Supervisorial District					Verification	
	1	2	3	4	5	Total	Variance
\$ 4,322		\$ 864			\$ 3,458	\$ 4,322	\$ -
15,127		\$ 3,025			\$ 12,102	15,127	-
12,776		\$ 2,555			\$ 10,221	12,776	-
25,620		\$ 5,124			\$ 20,496	25,620	-
16,720		\$ 3,344			\$ 13,376	16,720	-
13,860		\$ 2,772			\$ 11,088	13,860	-
-						-	-
-						-	-

This section is for verification only.

Employee Benefits

Enter employee benefit percentages and current budget (the most recent approved budget). The new amount requested, and the budget changes will be automatically calculated.

EMPLOYEE BENEFIT(S)(EB)	Allocated %	Current Budget	Budget Changes	Budget Request	1	2	3	4	5
FICA	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Social Security	0.00%		-	-	-	-	-	-	-
Retirement	0.00%		-	-	-	-	-	-	-
SUI	0.00%		-	-	-	-	-	-	-
Health Plan	0.00%		-	-	-	-	-	-	-
Worker's Compensation	0.00%		-	-	-	-	-	-	-
Long-Term Disability	0.00%		-	-	-	-	-	-	-
Life Insurance	0.00%		-	-	-	-	-	-	-
EMPLOYEE BENEFIT(S)(EB)	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Operating Costs

The agency must list all budget line items (hotel bed night, gift cards, client personal protective equipment, rent, utilities, telephone, etc.) as they appear in the most recent approved budget to ensure the current budget amounts in the budget modification match with the most recent approved budget. Please provide budget request amount that the agency would like to make changes based on current fiscal year's expenditures. Budget changes will be automatically calculated.

Please input the amount of each line item in the SD column(s) based on your agency's allocation.

OPERATING COSTS Service Description	Current Budget	Budget Changes	Budget Request	1	2	3	4	5
		-						
		-						
		-						
		-						
		-						
		-						
		-						
		-						
		-						
TOTAL OPERATING COSTS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

A concrete and reasonable justification for each budget line item explaining the necessity of the change and calculation of requested amount is needed in the narrative justification page. This will enable OWH’s staff to analyze the financial data to determine if the proposed costs are allocable to the program, and allowable under County, State and Federal cost principles and sponsorship guidelines (whichever is applicable).

Service Description	Detailed Justification (List all items and provide detailed calculation in each budget line)	Budget Request
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total Operating Costs		\$ -

Indirect Costs

If the contractor has a current NICRA established with a Federal cognizant agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals, then the contractor may use its current NICRA. If the contractor does not have a NICRA, the contractor may elect to use the de minimis rate of 10 percent of the modified total direct costs.

After completing budget modification worksheet, please ensure that total budget in the “Budget Changes” column is net zero. The budget modification allows contractors to move budgeted dollars from one-line item to another, and there is no impact to the total budgeted amount.

INVOICING/BILLING

Providers are required to submit a monthly invoice showing accurate billings for clients served during a month of service. Invoices are due no later than the 15th day of the month following

the month that the services were provided. For instance, invoices are due no later than September 15th for services provided in August.

The following items must be completed and submitted to OWHInvoice@ph.lacounty.gov

- Invoice (PDF version with E-Signature)
- Invoice (Excel version)
- ARP Monthly Report
- Assessment Form
- Receipts from the commercial lodging establishment for gift card, hotel/motel night, and Client Personal Protective Equipment (PPE), and documentation indicating that the client received the service/item (e.g., date received services/item, vendor name, name of client who received services/item, signature of client, and name and signature of authorized personnel who assisted the client).

Please note that only receipts and other pertinent documents that support the billing are required. The submission of additional documentation that is not relevant to the billing may delay the payment process.

For other Operating Costs such as rent, utilities, telephone, office supplies, etc., will be reviewed on the financial closeout report at the end of the contract term. OWH may require the submission of additional documentation that supports the cost reported.

Invoices will not be processed until all required program reports and data have been received.

The invoiced amounts must reflect actual costs incurred during that month. Invoiced amounts that merely reflect a prorated portion of the approved budget and not the actual cost will be disallowed. Only those line items and amounts that are included in your most recently approved budget will be reimbursed. Please bear in mind that stockpiling items to be used in a subsequent period is not allowed.

If no expenditures were incurred during the report month, please submit an invoice for the month reporting \$0 expenditures.

If no client was served during the report month, there won't be any payment issued to the subrecipient.

Supplemental Invoicing

Contractors are required to submit supplemental invoices no later than 60 days following the month of service provision with the exception of May and June. Supplemental invoices submitted beyond the 60-days will not be reimbursable. Supplemental invoices will not be allowed for June, and the May invoices must be submitted by June 30th.

Please note that supplemental invoices allow the agency to request for additional payment for services provided that were not included in the monthly invoices.

Invoice/Supplemental Invoice Instruction and Form

Please refer to the “Instructions” tab in the invoice/supplemental invoice form to complete the invoice.

If the agency submits a supplemental invoice, please select “Yes” in the Supplemental Invoice line on the invoice form. If the agency submits a monthly invoice, please do not complete this section.

The invoice must be signed and dated by the agency’s authorized staff. Payment requests will not be processed until authorized signatures are received.

Invoice Instructions	
Note:	Gray, Green, and yellow areas are locked and auto-calculated.
Invoice Tab:	<p>1) Contractor, Address, Contract Number, Contract Amount, Service Month/Year, Name of Staff Completing This Form, Title of Staff Completing This Form, Phone Number, Date Submitted: Please input information in these areas and it will be linked to "Add'l Personnel" tab.</p> <p>2) Supplemental Invoice: Please select "Yes" from the drop-down list if additional costs are identified for that month. This information is linked to "Add'l Personnel" tab.</p> <p>3) Salaries Table: Please input in columns: Employee Name, Payroll Title, and Expenditures by Supervisorial District (1 to 5). Total Expenditures column is locked and auto-calculated. If your salary line items are more than 20, please input additional lines in "Add'l Personnel" tab and the total amounts are linked to "Invoice" tab in the green row "from next page".</p> <p>4) Employee Benefits (EB): Please input amount(s) in Expenditures by Supervisorial District (1 to 5) column. Total Expenditures column is locked and auto-calculated.</p> <p>5) Total Salaries and EB: Locked and auto-calculated.</p> <p>6) Operating Costs: Please input in columns: Service Description and Expenditures by Supervisorial District (1 to 5). Total Expenditures column is locked and auto-calculated.</p> <p>7) Total Direct Costs: Locked and auto-calculated.</p> <p>8) Indirect Costs: Please input amount(s) in Expenditures by Supervisorial District (1 to 5) column. Total Expenditures column is locked and auto-calculated.</p> <p>9) Agency's Approval: The invoice must be signed by an authorized agency staff and dated.</p>
Add'l Personnel Tab:	<p>1) Contractor, Address, Contract Number, Contract Amount, Service Month/Year, Supplemental Invoice, Name of Staff Completing This Form, Title of Staff Completing This Form, Phone Number, and Date Submitted: linked from the "Invoice" tab.</p> <p>2) Salaries Table: refer to above "Salaries Table".</p>

FINANCIAL CLOSEOUT REPORT

The Financial Closeout Report is used to determine whether an agency's costs reconcile to their accounting records.

The agency should ensure that their financial records (Income Statement and General Ledger) reflect the actual costs related to ARP contract that incurred during the reporting period.

Please note OWH will be reviewing and matching expenditures found on the Financial Closeout Report against its corresponding approved budget line for each SD. Expenditures that are not in the budget or exceed the approved budget line will not be reimbursed. If your agency deems it necessary to reallocate the budget to accommodate significant shifts in expenditures incurred during the year, please submit your budget modification request no later than March 31st.

The annual closeout report is due to OWH no later than 30 days after the last month services were rendered. Please submit the following items to OWH Finance inbox at: OWHFinance@ph.lacounty.gov with the subject line: (AGENCY NAME) ARP Closeout Report FY 20xx-xx.

- Closeout Report Worksheet (Excel version)
- Financial Closeout Report Form (pdf version) – must signed by authorized agency representative on the pdf report
- Final Property Inventory Certification (pdf version) – must signed by authorized agency representative
- Agency's Income Statement (Excel version)
- Agency's General Ledger (Excel version)

Please note that failure to submit Financial Closeout Reports and supporting documents may result in withholding of payments for invoices for other funded contracted services that your agency has with OWH.

Please reflect the following information on the Closeout Report Worksheet by SD: the most recent approved budget, payments received from OWH for the contract term, and year-end expenditures and general ledger account/name that they appear in the agency's general ledger in each SD.

Financial Closeout Report Instruction and Form

Instructions

Note:	Please complete the information in the green highlighted areas. Gray and yellow areas are locked and auto-calculated.
Closeout Report Worksheet Tab:	<p>1) Contractor, Contract Number, and Contract Period: Please input contractor name, contract number, and contract period. This information is automatically transferred to the "Financial Closeout Report" and "Final Property Inventory" tabs.</p> <p>2) Budget Line Item/Description Column</p> <ul style="list-style-type: none">a) Salaries - Enter employee full nameb) Employee Benefits - Itemize all components of employee benefitsc) Operating Costs - Enter description for each line item. This information is automatically transferred to the "Financial Closeout Report" <p>3) Supervisorial District (SD) 1 to 5 Columns:</p> <ul style="list-style-type: none">a) Approved Budget - Reflect the most recent approved budget for each SD. The budget amount for each line item is included in the calculation in "Approved Budget" column in the "Financial Closeout Report" tab.b) Payments Received - Enter payment amount that has been received for each SD. The payment amount for each line item is included in the calculation in "Payments Received" column in the "Financial Closeout Report" tab.c) Year-End Expenditures - Enter the expenditure amount by SD for each line item as reflected on your agency's General Ledger. The expenditure amount for each line item is included in the calculation in "Year-End Expenditures" column in the "Financial Closeout Report" tab.d) General Ledger Account/Name - Enter account number or account name for each SD as shown on your agency's General Ledger.
Financial Closeout Report Tab:	<p>Please reflect:</p> <ul style="list-style-type: none">a) Name of Preparer, Title, and Telephone Numberc) Name of Authorized Agency Representative and Titled) Signature and Date <p>All other information is automatically transferred from the "Closeout Report Worksheet" tab.</p>
Final Property Inventory Tab:	<ul style="list-style-type: none">1) Acquisition of Property - Please mark the applicable selection on the Form.2) Complete the inventory listing detailed section if the agency has marked contract agreement with property3) This form must be signed and dated by authorized agency representative. <p>All other information is transferred automatically from the "Closeout Report Worksheet" tab.</p>

Closeout Report Worksheet

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
 OFFICE OF WOMEN'S HEALTH
 AMERICAN RESCUE PLAN FOR DOMESTIC VIOLENCE SHELTER & SUPPORTIVE SERVICES PROJECT
 ANNUAL COST REPORT WORKSHEET

Contractor: _____
 Contract Number: _____
 Contract Period: _____

Budget Line Item/Description	Supervisory District 1				Supervisory District 2				Supervisory District 3				Supervisory District 4				Supervisory District 5			
	Approved Budget	Payments Received	Year-End Expenditures	General Ledger Account Number/Name	Approved Budget	Payments Received	Year-End Expenditures	General Ledger Account Number/Name	Approved Budget	Payments Received	Year-End Expenditures	General Ledger Account Number/Name	Approved Budget	Payments Received	Year-End Expenditures	General Ledger Account Number/Name	Approved Budget	Payments Received	Year-End Expenditures	General Ledger Account Number/Name
I. DIRECT COSTS																				
Employee Name:																				
*																				
*																				
*																				
*																				
*																				
*																				
*																				
*																				
*																				
SUBTOTAL SALARIES	\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$	
Employee Benefits (EB):																				
*																				
*																				
*																				
*																				
*																				
*																				
*																				
SUBTOTAL EMPLOYEE BENEFITS	\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$	
SUBTOTAL SALARIES AND EB:	\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$	
Operating Costs																				
*																				
*																				
*																				
*																				
*																				
*																				
*																				
*																				
SUBTOTAL OPERATING COSTS	\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$	
TOTAL DIRECT COSTS	\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$	
II. INDIRECT COSTS																				
Indirect Costs																				
TOTAL	\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$		\$	\$	\$	

Financial Closeout Report

**COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH
AMERICAN RESCUE PLAN FOR DOMESTIC VIOLENCE SHELTER & SUPPORTIVE SERVICES PROJECT
FINANCIAL CLOSEOUT REPORT**

Contractor:			
Contract Agreement No.:		Contract Period:	
I. DIRECT COSTS	APPROVED BUDGET	PAYMENTS RECEIVED	YEAR-END EXPENDITURES
Staff			
■ Salaries and Wages	\$ -	\$ -	\$ -
■ Fringe Benefits	-	-	-
SUBTOTAL STAFF COSTS:	\$ -	\$ -	\$ -
Operating Costs			
■	\$ -	\$ -	\$ -
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
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■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
■	-	-	-
SUBTOTAL OPERATING COSTS:	\$ -	\$ -	\$ -
TOTAL DIRECT COSTS	\$ -	\$ -	\$ -
II. INDIRECT COSTS			
■ Indirect Costs	%	\$ -	\$ -
TOTAL			
	\$ -	\$ -	\$ -

III. CERTIFICATION

I hereby certify to the best of my knowledge and belief that this Financial Closeout Report is a true and accurate presentation of actual expenditures made during the reporting period and that these expenditures were made in accordance with the purpose and conditions of the Contract Agreement referenced above.

Name of Preparer	Title Telephone Number
Name of Authorized Agency Representative	Title
Signature	Date

Final Property Inventory

LOS ANGELES COUNTY- DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH
FINAL PROPERTY INVENTORY CERTIFICATION
(Property Acquired With Program Funding Only)

Contractor:	Contract Type: AMERICAN RESCUE PLAN FOR DOMESTIC VIOLENCE SHELTER & SUPPORTIVE SERVICES PROJECT
Contract Agreement No:	Contract Agreement Period:

I. ACQUISITION OF PROPERTY

Please mark the applicable selection.

- Contract Agreement Without Property**
I hereby certify that no property/equipment was furnished or acquired according to the terms and conditions of this Master Agreement.
- Contract Agreement With Property**
I hereby certify that the inventory listing detailed below is complete, and that it correctly reflects all property/equipment furnished or purchased under the terms and conditions of this award. (Attach additional pages

Property/Equipment Details	ID# (e.g., stock no., serial no., property tag no., etc.)	Location of Property/Equip.	Acquisition Date	Acquisition Cost	Current Value	Condition

Name of Authorized Agency Representative

Title

Signature

Date