

STATE OF CALIFORNIA
 CALIFORNIA DEPARTMENT OF AGING
**CALFRESH EXPANSION REQUEST FOR REIMBURSEMENT/EXPENDITURE
 REPORT**
 CDA 7010 (REV 11/2019)



		Invoice #:	FI\$Cal PO#:
PSA#:	Fiscal Year:	Contract No: CF-1920-	Invoice Date:
Remit to Name:			
Remit to Address:			

PART I: EXPENDITURE REPORT

Expenditure Month:		Fiscal Year:	
COST	PROGRAM	ADMIN	TOTAL COSTS
Personnel Salaries			
Fringe Benefits			
Operating Expenses			
Equipment			
Travel and Per Diem			
Subcontractors			
Other Costs			
Indirect Costs			
Total Costs			

PART II: MONTHLY REIMBURSEMENT REQUEST FOR FUNDS

Complete Part II for REIMBURSEMENT REQUESTS. Amounts must agree with expenditure amounts reported in PART I .			
Request Month:		Fiscal Year:	
CalFresh Expansion	PROGRAM	ADMIN	TOTAL
Amount to be Reimbursed			

FOR STATE USE ONLY			
Fiscal Team Analyst:	Date:	Fiscal Policy Manager:	Date: