STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
**DIGNITY AT HOME FALL PREVENTION PROGRAM REQUEST FOR REIMBURSEMENT**
CDA 259 (NEW 01/2020)

| | | Invoice #: | FI$Cal PO#: |
|---|---|---|---|
| PSA#: | Fiscal Year: | Contract No: - - 0 0 | Invoice Date: |
| Remit to Name: | | | |
| Remit to Address: | | | |

**PART I: EXPENDITURE REPORT**

| **Expenditure Month:** | **Fiscal Year:** |
|---|---|
| **COST** | **PROGRAM TOTAL** |
| A) Direct Costs | |
| Salaries/Benefits | |
| In State Travel | |
| Equipment | |
| Consultant Costs | |
| Training | |
| Other Costs | |
| Purchased Fall Prevention Services | |
| B) Administration Costs | |
| Administration (maximum 10%) | |
| C) Indirect Costs | |
| Indirect Costs (maximum 10%) | |
| D) Contractual Costs | |
| Subcontractors | |
| Total Costs | $ 0 |

**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:** |
| **Dignity at Home Fall Prevention Program** | **TOTAL** |
| Amount to be Reimbursed | $ 0 |

| **FOR STATE USE ONLY** | | |
|---|---|---|
| Approved By: | Authorized Signature: | Date: |