

## Special Education Federal Grant Expenditure Report: Mental Health Average Daily Attendance Allocation

Refer to the AO-400 Grant Award Notification (GAN) to complete this form.

Return completed form to: Mental Health Average Daily Attendance Team at [MHADA@cde.ca.gov](mailto:MHADA@cde.ca.gov).

**Grant Fiscal Year:** \_\_\_\_\_ **Program Cost Account:** 15197

**Standardized Account Code Structure Resource Code:** 3327

**Name of Grant Program:** Mental Health Average Daily Attendance Allocation

**Local Educational Agency (LEA) Name:** \_\_\_\_\_

**Unique Entity ID:** \_\_\_\_\_ **Mental Health Region Group:** \_\_\_\_\_

**Service Location Number:** \_\_\_\_\_ **Suffix:** \_\_\_\_\_

### Report Periods

Refer to the Expenditure Report (ER) Instructions page for report periods 1 through 3, accompanying due dates, and reimbursement requirements.

Check the appropriate box(es) to indicate the reporting period for this report. If the Report is Final, please ensure that the Final Report box is checked.

- Report 1
- Report 2
- Report 3
- Final Report

### Final Report

The Grantee may submit a Final ER prior to the award ending date if funds have been fully expended. Upon receipt of the Final ER, the California Department of Education (CDE) will issue up to 100 percent of the total grant award. Please refer to either the GAN or the Expenditure Report Instructions page for reporting requirements.

### Expenditures Summary

Items A through H must be filled in. Where applicable, enter \$0.00.

Description	Amount
<b>A. Total Award Grant Amount</b>	
B. Prior Cumulative Actual Expenditures Reported	
C. Current Actual Expenditures	
<b>D. Total Combined Actual Expenditures (B and C)</b>	
E. Cash Payments Received	
F. Reimbursement Claimed (D minus E)	
G. Indicate Total Indirect Cost Rate: Total Indirect Cost (Enter dollar amount in box)	
H. Unused Balance (A minus D)	

## Required Assurance

Grantees assure that the following number of students served **during this reporting period** have a valid individualized education program (IEP) with mental health service requirements. All reported expenditures are for direct educationally related mental health services as stated on a student's IEP, or indirect costs at the CDE-approved rate for LEAs.

### Students Served

## Supplemental Form

Grantees must complete the Detailed Summary of Mental Health Expenditures Worksheet and have backup documentation of expenditures available upon request. For auditing purposes, it is the responsibility of the Grantee to complete the required supplemental form and keep it on file, as the CDE may request submission of the form at any point. Upon receipt of the ER, payment will be determined by the expenditures reported and issued on a reimbursement basis.

## Certification

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements, and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative penalties for fraud, false statements, false claims, or otherwise (*United States Code* Title 18, Section 1001 and Title 31, sections 3729–3730 and 3801–3812). Full records of receipts and expenditures have been maintained and are available for a period of five years after submission of a Final Expenditure Report.

**Name of Authorized Agent**

**Title of Authorized Agent**

**Name of Contact Person**

**Title of Contact Person**

**Contact Person Email**

**Contact Person Phone**

**Signature of Authorized Agent**

**Date**

## For CDE Use Only

**Approved by:**

**Date Approved:**

**Voucher Number:**

**Payment Identifier:**

**Interim Payment:**

**Final Payment:**

**Comments:**