

STATE OF CALIFORNIA
 CALIFORNIA DEPARTMENT OF AGING
HICAP REQUEST FOR FUNDS
 CDA 245 (REV 09/2021)



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

REQUEST FOR FUNDS OR REIMBURSEMENT								
				Month:		Year:		
Fund	HICAP REIMB		HICAP FUND		HICAP FEDERAL		HICAP AUGMENT	TOTAL
	Program	Admin	Program	Admin	Program	Admin	Program	
Total								

FOR STATE USE ONLY	
Local Finance Bureau Analyst Signature & Date:	Local Finance Bureau Manager Signature & Date: