

**NC DEPARTMENT OF HEALTH & HUMAN SERVICES
NC COUNCIL ON DEVELOPMENTAL DISABILITIES
REQUEST FOR REIMBURSEMENT**

GRANTEE NAME:

PA BEGIN

GRANTEE ADDRESS:

PA END

PROJECT NAME:

OUTLAYS FOR PERIOD: _____ - _____

DUE DATE 1/15/00

CATEGORIES OF EXPENSE	DD FUNDS	CASH MATCH	IN-KIND MATCH	TOTAL
SALARIES	_____	_____	_____	_____
FRINGE BENEFITS	_____	_____	_____	_____
SUPPLIES	_____	_____	_____	_____
STAFF TRAVEL	_____	_____	_____	_____
COST OF SPACE	_____	_____	_____	_____
EQUIPMENT	_____	_____	_____	_____
CONTRACTED SERVICES	_____	_____	_____	_____
OTHER EXPENSES	_____	_____	_____	_____
INDIRECT COST	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____
	(amount being requested)			

