

		PROJECT BUDGET PERIOD:	County: _____ Grant Award # _____	Mail Completed Form To:
Check here if this is a revised claim		From ___/___/___ To: ___/___/___	Grantee: _____ (County Agency identified as Grantee on the Notice of Grant Award)	Department of Alcohol and Drug Programs Office of Drug Court Programs CDCI Program Coordinator 1700 K Streets, 5th Floor Sacramento, CA 95814-4022
	<input type="checkbox"/>	BILLING PERIOD COVERED BY THIS CLAIM:	Address: _____	
		From ___/___/___ To: ___/___/___	City/Zip: _____	
			Phone: _____ Email Address: _____	

Important Notes:

1. Adult Drug Court line item budget must equal or be greater than the County's portion of the augmented \$2.3 million for 2003/2004.
2. Juvenile, Dependency, and Family Drug Court line item budget must be equal or less than the county's base allocation amount.
3. Grand Total must equal the county's total allocation amount, total of Section I and Section II.

Section I. ADULT DRUG COURT: Budget and Current Expenditures

A	B	C	D	E	F	G	I	J
BUDGET LINE ITEMS	Budget	Beginning Balance	Budget Line Item Change (Justification Required)	Treatment Related Costs	Court Related and Other Costs (Must be less than 15% of total allocation)	Ending Balance (Do not include Match Amount) (Columns C+D-E-F=G)	20 Percent Match Requirement	
							This Quarter	Cumulative
Personnel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Fringe Benefits	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractual Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Indirect Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL OF SECTION I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Section II. JUVENILE DRUG COURT, DEPENDENCY DRUG COURT, FAMILY DRUG COURT: Budget and Current Expenditures

A	B	C	D	E	F	G	I	J
BUDGET LINE ITEMS	Budget	Beginning Balance	Budget Line Item Change (Justification Required)	Treatment Related Costs	Court Related and Other Costs (Must be less than 15% of total allocation)	Ending Balance (Do not include Match Amount) (Columns C+D-E-F=G)	20 Percent Match Requirement	
							This Quarter	Cumulative
Personnel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Fringe Benefits	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other Admin Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractual Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Indirect Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL OF SECTION II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
GRAND TOTAL OF SECTIONS I AND II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Section III. CERTIFICATION [(Please sign with BLUE ink.) Reimbursement will not be approved unless a copy of this quarter's NARRATIVE REPORT IS ATTACHED.]

County Alcohol and Other Drug (AOD) Program Administrator's certification that all expenditures claimed above are consistent with the requirements of the county's grant award and that a copy of this quarter's narrative report is attached.

X _____ AOD Administrator's Signature	Date: ___/___/___	_____ AOD Administrator's Printed Name
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Department of Alcohol and Drug Programs Office of Drug Court Programs Use Only

I hereby certify that the required reports for the above billing period have been received. The fiscal data contained in this invoice has been recorded and submitted to ADP's Accounting Office

Comprehensive Drug Court Implementation Program Coordinator: _____ Date: ___/___/___

ADP Accounting Section Use Only

TC Number :	FY:	Index Code:	PCA Number:
Vendor Number:	Grant:		