PAYMENT OF UNLIQUIDATED ACCRUAL BALANCES

Date: _____

_____Health Department is submitting Check #_____,

in the amount of **$**_____**.** This amount represents the balance of unliquidated accruals as of January 31, _____ for:

County Code/PCA: _____

Fiscal Year: _____

CASHIER: DO NOT PROCESS WITHOUT CONFERRING WITH THE DIVISION OF GRANTS AND LOCAL HEALTH ACCOUNTING WHO WILL SUPPLY INFORMATION BELOW.

FOR GRANTS SECTION USE ONLY

Please deposit payment as follows:

PCA Number(s)	Object Source(s)	Amount(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REV 7/2024