CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

915 Capitol Mall, Suite 435, Sacramento, CA 95814

The Lifeline Grant Program

Request for Disbursement

Date _____

Name of Grantee _____

Grantee requests the following disbursement of grant proceeds from CHFFA:

Amount Requested	**Date Funds Needed** *
$ _____	_____

* Note: Date must be a minimum of three weeks from CHFFA's receipt of this disbursement request.

Description of how the Grant Funds will be used **

_____

_____

_____

_____

**Note: Attach additional pages as needed

Documentation to Accompany Request

Please attach contracts, payroll reports, purchase orders, invoices and proof of payment of those invoices as documentation to substantiate this disbursement request.

By: _____
(Authorized Officer)

Print Name: _____

Title: _____

For CHFFA Use Only:

Approved Grant Amount	**$**	_____
Disbursement Request		_____
Balance Remaining	**$**	_____

_____ Analyst Signature

_____ Project Manager Signature

_____ Executive Director Signature