

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:

Grant Number _____

Fiscal Year _____



FOR GRANTS SECTION USE ONLY

Please deposit payment accordingly:

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