

**CARE Act Quarterly Administrative Cost Reimbursement Claim**

Date: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_ County: \_\_\_\_\_ County Code: \_\_\_\_\_

Quarter: \_\_\_\_\_ Number of CARE Act Participants: \_\_\_\_\_

Activity	Total Hours	Activity Rate	Total Claim Amount
Court Report Activity			
Court Hearing Time Activity			
Notice Activity			
Outreach and Engagement Activity			
Data Reporting			
Total Claim:			

**Certification**

Executed at: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

I certify that the staff hours spent on CARE Act activities are accurate and verifiable.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_