STATE OF OREGON PARKS AND RECREATION DEPARTMENT
REQUEST FOR GRANT REIMBURSEMENT

Grant Type	☐ LWCF	☐ ATV	☐ RTP	☐ Local Gov.	☐ RV	☐ Veteran's

Project Sponsor:		Project #	
Project Name:			
Date Work Started:	Billing Period:		to
Date of Approval:		Billing#	Billing: Partial ☐ Final

Project / Grant Summary (Per Agreement)

Grant Amount	$
Sponsors Match Percentage	
Sponsors Contributions	$
Maximum State Reimbursement	$

Comments:

DETAIL PROJECT COSTS

TYPE OF EXPENSE	Costs Incurred This Period	Cost Previously Billed	Total Project Costs to Date
Salaries and Wages (Agency Force Account)			
Contract Payments			
Equipment Rental (Owned/Outside)			
Materials and Supplies			
Consultant Services (Design/Engineering)			
Value of Approved Donations (Donated labor, materials and equipment)			
Approved Pre-Agreement Costs			
Real Property Costs			
Other			
Other			
Other			
Other			
Other			
A. TOTAL PROJECT COSTS			
B. Less Costs in Excess of Agreement			
C. TOTAL ELIGIBLE COSTS			
D. Sponsor Match (Multiply C by Required Match %)			
E. TOTAL REIMBURSEMENT REQUEST (C minus D = E)			

Documentation Supporting Expenditures and Match will be required for every Reimbursement.

I certify that this billing is correct and is based on actual costs incurred and can be supported with documentation on file with the sponsor.

I also certify that the work and services which have been performed to date are in accordance with the approved project agreement including amendments thereto; and that this Sponsor has complied with al applicable State and local statutes.

I agree to retain records pertaining to this billing for three years past the project completion date.

I certify that this Sponsor, is not involved in any court litigation or lawsuit wherein it is alleged by private parties of the United States that persons were, on the grounds of race, color, or natural origin excluded from participation in, denied benefits of, or otherwise subject to discrimination in the programs or facilities of this Sponsor.

Signature:_____ **Date:**_____

Contact:_____ **Telephone#** _____

For OPRD Use Only:

Authorized Payment by:_____ **Date:**_____

Amount of Reimbursement:_____ **Amount of Admin Costs (LWCF)**_____