

**DHHS Certification of Cash Needs (ARRA) - Community Services Block Grant Program**

Name of Agency: \_\_\_\_\_  
 Federal Identification Number: \_\_\_\_\_  
 Agency Fiscal Year: \_\_\_\_\_  
 Certification for the Month/Year of: \_\_\_\_\_  
 Contract Number: \_\_\_\_\_  
 Name of DHHS division/office administering the grant award: \_\_\_\_\_

As a recipient of financial assistance funds from the N. C. Department of Health and Human Services, we have determined our monthly cash requirements as a condition of requesting a cash advance. As duly authorized officials of the above-named agency, we hereby certify that, to the best of our knowledge, the amount of the cash advance request represents our true cash needs. We agree to monitor our cash flow needs on a monthly basis, and if these needs change or if the need for a cash advance ceases to exist, we will submit a revised Certification of Cash Needs.

\_\_\_\_\_  
 Signature of Executive Director      Date      Signature of Chief Financial Officer      Date

Breakdown of Advance Request:

\$ _____	Operating costs (ongoing)
\$ _____	Capital costs (one-time)
\$ _____	Start-up costs
\$ _____	Total Amount of Advance Request

IMPORTANT: If you are requesting an Operating Advance, you must indicate the number of days that the advance covers by checking the appropriate item as follows:  
 \_\_\_\_\_ 30-day      \_\_\_\_\_ 60-day      \_\_\_\_\_ Other (Specify: \_\_\_\_ days)

Please provide a brief narrative as to why the advance is needed:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

BELOW THIS LINE TO BE COMPLETED ONLY BY THE RESPONSIBLE DHHS DIVISION/OFFICE:

_____ Approved	_____	_____
_____ Disapproved	Director	Signature of Division      Date