

NAVIGATOR GRANT PAYMENT REQUEST

Covered California (Rev. 01/16)

FY 2015 - 2016**Complete the information requested.**

1. GRANTEE NAME (AS APPEARS ON GRANT AGREEMENT)		2. GRANT AGREEMENT NUMBER (ASSIGNED BY COVERED CA)	
3. PAYMENT REQUEST PERIOD <input type="checkbox"/> Aug-Oct 2015 <input type="checkbox"/> December 2015 <input type="checkbox"/> February 2016 <input type="checkbox"/> April 2016 <input type="checkbox"/> June 2016			
4. TYPE OF PAYMENT REQUEST <input type="checkbox"/> Reimbursement <input type="checkbox"/> Final			
5. SEND WARRANT TO:			
GRANTEE NAME (e.g. Entity/Organization Name)			
CONTACT NAME			
ADDRESS			
CITY		STATE	ZIP CODE
6. I certify, under penalty of perjury under the laws of the State of California, that the above information is true and correct and that all costs for which reimbursement is requested herein were incurred in accordance with the above referenced California Health Benefit Exchange and Navigator Grant Program Agreement.			
_____		_____	
<i>Signature of Authority / Authorized Designee</i>		<i>Date</i>	
_____		_____	
<i>Print Name</i>		<i>Title</i>	
Covered CA Staff Use Only			
7. ALL DELIVERABLES and PRIOR MONTHLY PROGRESS REPORTS RECEIVED		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. APPROVED FOR PAYMENT		<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. AMOUNT APPROVED FOR PAYMENT		\$	
10. COMMENTS		11. DATE RECEIVED	
_____		_____	
<i>Approval Signature of Navigator Grant Program Analyst</i>		<i>Print Name</i>	<i>Date Approved</i>
_____		_____	
<i>Approval Signature of Navigator Grant Program Manager</i>		<i>Print Name</i>	<i>Date Approved</i>

See instructions on reverse side

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FY 2015 - 2016**Information and instructions for completing the form.**

SECTION	TITLE	DESCRIPTION
1.	GRANTEE NAME (AS APPEARS ON THE GRANT AGREEMENT)	Organization or business name as it appears on the grant agreement
2.	GRANT NUMBER (ASSIGNED BY COVERED CA)	Grant Agreement number assigned by Covered CA as it appears on the grant agreement
3.	PAYMENT REQUEST PERIOD	The month(s) that payment is being requested for
4.	TYPE OF PAYMENT REQUEST	Reimbursement– the typical payment request is paid on a reimbursement basis Final– final grant payment request for the project
5.	SEND WARRANT TO	Grantee's name, contact name, address, city, state, and zip code as it appears on the grant agreement
6.	CERTIFICATION	The signature of an authorized person, or person designated to sign on behalf of the authorized – as recognized by Covered CA ; printed name; title; and date

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SECTION	TITLE	DESCRIPTION
7.	ALL DELIVERABLES AND PRIOR MONTHLY PROGRESS REPORTS RECEIVED	Yes or no, have all deliverables and prior monthly progress reports been received
8.	APPROVED FOR PAYMENT	Yes or no, is the payment request approved for payment
9.	AMOUNT APPROVED FOR PAYMENT	Amount approved for payment by the Navigator Grant Program Manager
10.	COMMENTS	Comments about additions, deductions or general comments related to this payment request
11.	DATE RECEIVED	Date payment request was received by the Navigator Grant Program

Send Navigator Grant Payment Request to:E-mail: NavigatorProgram@covered.ca.gov**OR**

Mail: *California Health Benefit Exchange
Sales Division – Navigator Grant Program
ATTN: Lezlie Micheletti
1601 Exposition Blvd.
Sacramento, CA 95815*