STATE OF CALIFORNIA

NAVIGATOR GRANT PAYMENT REQUEST

Covered California (Rev. 09/16)

California Health Benefit Exchange (Covered California)

FY 2016 - 2017

Complete the information requested.

1. GRANTEE NAME (AS APPEARS ON GRANT AGREEMENT)	2. GRANT AGREEMENT NUMBER (ASSIGNED BY COVERED CA)

3. PAYMENT REQUEST PERIOD ☐ Oct. 10, 2016 ☐ Dec. 10, 2016 ☐ Feb. 10 2017 ☐ May 10, 2017 ☐ June 30, 2017

4. TYPE OF PAYMENT REQUEST ☐ Reimbursement ☐ Final AMOUNT REQUESTED

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.**

Signature of Authority / Authorized Designee *Date*

Print Name *Title*

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7. **ALL DELIVERABLES and PRIOR MONTHLY PROGRESS REPORTS RECEIVED**	☐ Yes ☐ No
8. **APPROVED FOR PAYMENT**	☐ Yes ☐ No
9. **AMOUNT APPROVED FOR PAYMENT**	**$**
10. COMMENTS	11. DATE RECEIVED

Approval Signature of Account Services Representative *Print Name* *Date Approved*

Approval Signature of Account Services Manager *Print Name* *Date Approved*

See instructions on reverse side

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 *Amount Requested* – amount requested for this payment
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*
Outreach & Sales Division – Account Services Section
ATTN: Lydia Hernandez-Luna
1601 Exposition Blvd.
Sacramento, CA 95815