

**NAVIGATOR GRANT PAYMENT REQUEST**

Covered California (Rev. 10/17)

**FY 2017 - 2018****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"/> Oct. 10, 2017 <input type="checkbox"/> Dec. 10, 2017 <input type="checkbox"/> Feb. 10 2018 <input type="checkbox"/> May 10, 2018 <input type="checkbox"/> June 15, 2018			
4. TYPE OF PAYMENT REQUEST <input type="checkbox"/> Reimbursement <input type="checkbox"/> 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.			
_____		_____	
<i>Signature of Authority / Authorized Designee</i>		<i>Date</i>	
_____		_____	
<i>Print Name</i>		<i>Title</i>	
<b>Covered CA Staff Use Only</b>			
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 Account Services Representative</i>		<i>Print Name</i>	<i>Date Approved</i>
_____		_____	_____
<i>Approval Signature of Account Services Manager</i>		<i>Print Name</i>	<i>Date Approved</i>

See instructions on reverse side

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**FY 2017 - 2018****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	<i>Reimbursement</i> – the typical payment request is paid on a reimbursement basis <i>Final</i> – final grant payment request for the project <i>Amount Requested</i> – 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

**Covered CA Staff Use Only**

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: [CommunityPartners@covered.ca.gov](mailto:CommunityPartners@covered.ca.gov)**OR**

Mail: California Health Benefit Exchange  
 Outreach & Sales Division – Account Services Section  
 ATTN: Benjamin Walker  
 1601 Exposition Blvd.  
 Sacramento, CA 95815