

WEST VIRGINIA DEPARTMENTS OF HEALTH, HEALTH FACILITIES, AND HUMAN SERVICES
SWORN STATEMENT OF EXPENDITURES

Grant Number:	Grantee Name:		
Grantee FEIN:	wwOASIS Vendor #:	Contact Name:	
Contact Email Address:		Contact Phone:	
Grantee Mailing Address:			
Total Amount of Grant Award:		Grant Period:	

Grant Revenues (received and anticipated)		
Revenue Categories	Comments	Amount
Amount Received		
Amount Anticipated		
Total Grant Revenues		

Grant Expenditures (allowable costs expended by the grantee)		
Expenditure Categories	Comments	Amount
Personnel		
Fringe Benefits		
Equipment		
Supplies		
Contractual Costs		
Construction		
Other		
Indirect Cost		
Total Grant Expenditures		

Ending Grant Balance (Revenues – Expenditures)

Grant Funds Returned to the Department

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete and accurate, and that the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal (and/or State) award. I am aware that any false, fictitious or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729–3730 and 3801–3812).

Authorized Signature: _____ **Date:** _____

Printed Name and Title: _____

Taken, sworn and subscribed before me this ____ day of _____, 20____.

Notary Public Signature: _____

My Commission Expires: _____