HOUSING OPPORTUNITIES FOR PEOPLE WITH AIDS
REQUEST FOR FUNDS

Project Sponsor:_____ Contract Number: HOPWA____
Contact Person:_____ Telephone:_____
E-mail Address:_____ Fax:_____

REQUEST NUMBER:_____ **DATE SUBMITTED:_____**

Appropriate documentation (receipts, invoices, etc.) must accompany this request. A completed Hourly Rate Calculation must be on file and a Client Billing Sheet must accompany all requests for salary reimbursements. Further documentation (i.e. time sheets, benefits documentation, etc.) may be requested, and hours may be verified during monitoring visits.

HOPWA Cost Category	**Allowable Cost incurred**	**IHFA approved amount** Office use only	**Total by HOPWA category** Office use only
Supportive Services			
STRMU			
Total	**$**		**$**
Admin (support with documentation)			
Total	**$**		**$**
TBRA			
Total	**$**		**$**
Total Draw	$	**Total Draw**	**$**

CERTIFICATION: By signing below, I certify that the above data is correct based on our (sponsor's) official accounting system and records, and the expenditures shown have been made for the purposes stated, and are in accordance with the contract terms and conditions, and conditions of the program. I further certify that the funds requested are for reimbursement of actual expenses and have not been previously requested.

FOR IHFA USE ONLY

_____ _____
Authorized Sponsor Signature Date IHFA Reviewed

_____ _____
Printed Sponsor Name and Title IHFA Approved