

Date:

Contract Manager   
 California Department of Public Health  
 Maternal, Child and Adolescent Health  
 MS 8305  
 P.O. Box 997420  
 Sacramento, CA 95899-7420

Dear Contract Manager:

Enclosed for approval is our request for initial allotment pursuant to the terms and conditions established in the agreement. By signing below, we agree with the recovery schedule listed, and understand these amounts will be deducted from our invoices as referenced in this request.

**Note:** Initial Allotment is only available to Community Based Organizations (CBOs). This must be requested by August 1st of each fiscal year.

Program	Information and Education		
Agency Name:	<span style="border: 1px solid black; background-color: yellow; display: inline-block; width: 400px; height: 15px;"></span>		
Agreement Number:	16-10045		
Fiscal Year:	<span style="border: 1px solid black; background-color: yellow; display: inline-block; width: 400px; height: 15px;"></span>		
Budget Period:	<span style="border: 1px solid black; background-color: yellow; display: inline-block; width: 400px; height: 15px;"></span>		
Requested Allotment:	Percentage	25%	Annual Total Award
	Percentage not to exceed 25% of the Annual Total.		

Recovery Schedule:	Quarter 1	Quarter 2	Quarter 3	Rounded Total	
From Unmatched	33.33%	33.33%	33.33%	100.00%	<span style="color: red; font-weight: bold;">If Necessary:</span> <span style="border: 1px solid black; padding: 2px;">Quarter 4</span> <span style="border: 1px solid black; padding: 2px;">Remaining Balance</span>
State General Funds	\$0	\$0	\$0	\$0	

Sincerely,

\_\_\_\_\_  
Signature of Authorized Agency Official

Printed Name and Title of Agency Official