

**CITY OF NEWPORT NEWS
Community Support Agency Grant (CSAG) Program**

THIRD PAYMENT REQUEST (due January 15)

Agency Name: _____
Agency Address: _____

City, State, ZIP Code _____
Agency Telephone Number: _____
Agency Fax Number: _____
Typed Name of Preparer: _____

Total Amount of Grant: \$ _____
Less Funds Paid Previously: \$ _____
Balance to Date: \$ _____
Funds Requested This Date (25% of total grant): \$ _____
Balance After This Request: \$ _____

An advance of 25% of the grant allocation is hereby requested to cover anticipated expenditures of the agency.

Typed Name of Authorized Official: _____
Signature of Authorized Official: _____
Date of Signature: _____

Submit this form, along with completed service and financial reports for the first six months, and an independent audit of your agency's most recently completed fiscal year, and mail to your agency's CSAG contact (refer to your grant award letter to determine your agency's CSAG contact).

City of Newport News
Department of Human Services
Accounting Coordinator or
6060 Jefferson Avenue
Newport News, VA 23605-3014
(757) 926-6342

City of Newport News
Department of Budget & Evaluation
2400 Washington Avenue, 9th Floor
Newport News, VA 23607
(757) 926-8733