| Temporary A | Assistance for Needy Families (TANI | F) Financial Report |
|---|---|---|
| | | |
| | | |
| STATE | FISCAL YEAR | |
| SUBMISSION (MARK ONE BOX) [] Regular Quarterly [] Revision | CURRENT QUARTER ENDED | NEXT QUARTER ENDING |
| ITEMS | (a) TOTAL FY 19 EXPENDITURES | (b) CUMULATIVE ESTIMATES |
| | | |
| 1 Tatal Evnandikunas Elinikla Ean Eadaral | STATE FAMILY ASSISTANCE GRANT (SFA | G) |
| 1. Total Expenditures Eligible For Federal Financial Participation (FFP) | \$ | \$ |
| 2. Payments Including Systems Costs | \$ | |
| 3. Administration | \$ | |
| 4. State Share | \$ | \$ |
| 5. Less Penalties/Audits/Etc | \$ | |
| 6. Federal Share | \$ | \$ |
| 7. Funds Transferred to Other Programs | \$ | |
| | | |
| | CONTINGENCY FUND | |
| 1. Total Expenditures Eligible For Federal Financial Participation (FFP) | \$ | |
| 2. Administration | \$ | |
| 3. Federal Share | \$ | \$ |
| 4. State Share | \$ | |
| | | |
| | LOAN REPAYMENT | |
| | CUMULATIVE REPAYMENTS | OUTSTANDING BALANCE |
| 1. Principle & Interest | \$ | \$ |
| | | |
| | information reported on all parts of this form is accurate and true to t | |
| ignature: State Official | are of expenditures estimated is or will be available to meet the non-l Typed Name, Title, Agency Name | reueral share of expenditures as required by law. |
| ate Submitted: | For Federal Use Only Rec'd | ADP |
| age 1 of 1 Approved OMB No. xxxx-xxxx | | |
| orm ACF- XXX (XX/XX) | | |

Department of Health and Human Services

Administration for Children and Families

| Temporary | Assistance for Needy Families (TA | NF) Financial Report |
|---|---|---|
| | | |
| | | |
| STATE | FISCAL YEAR | |
| SUBMISSION (MARK ONE BOX) [] Regular Quarterly [] Revision | CURRENT QUARTER ENDED | NEXT QUARTER ENDING |
| ITEMS | (a) TOTAL FY 19 EXPENDITURES | (b) CUMULATIVE ESTIMATES |
| | | |
| | STATE FAMILY ASSISTANCE GRANT (SF | AG) |
| 1. Total Expenditures Eligible For Federal Financial Participation (FFP) | \$ | \$ |
| 2. Payments Including Systems Costs | \$ | |
| 3. Administration | \$ | |
| 4. State Share | \$ | \$ |
| 5. Less Penalties/Audits/Etc | \$ | |
| 6. Federal Share | \$ | \$ |
| 7. Funds Transferred to Other Programs | \$ | |
| | | |
| | LOAN REPAYMENT | |
| | CUMULATIVE REPAYMENTS | OUTSTANDING BALANCE |
| 1. Principal & Interest | \$ | \$ |
| | | |
| - | information reported on all parts of this form is accurate and true | |
| Signature: State Official | hare of expenditures estimated is or will be available to meet the no Typed Name, Title, Agency Name | mercucial share of expenditures as required by law. |
| Date Submitted: | For Federal Use Only Rec'd | ADP |
| Page 1 of 1 Approved OMB No. xxxx-xxxx | | |
| Form ACF- XXX (XX/XX) | | |

Department of Health and Human Services

| | Temporary Assistance for ACF-196 Finan | - | |
|---|---|---|---|
| | DRAFT - DRAF | | |
| STATE: | FISCAL YEAR | CURRENT QUARTER ENDED: | NEXT QUARTER ENDED: |
| | STATE FAMILY ASSISTA | NCE GRANT (SFAG) | |
| | Cumulative | | |
| ITEMS | TOTAL FEDERAL EXPENDITURES/OUTLAYS | TOTAL FEDERAL UNLIQUIDATED OBLIGATIONS | TOTAL FEDERAL EXPENDITURES/OUTLAYS AND UNLIQUIDATED OBLIGATIONS |
| 1. Cash Assistance | \$ | \$ | \$ |
| 2. Administration | \$ | \$ | \$ |
| 3. Systems | \$ | \$ | \$ |
| 4. Support Services | \$ | \$ | \$ |
| 5. Child Care | \$ | \$ | \$ |
| 6. Work Activities | \$ | \$ | \$ |
| a. Training | \$ | \$ | \$ |
| b. Education | \$ | \$ | \$ |
| c. Work Subsidies | \$ | \$ | \$ |
| 7. Individual Development Accounts | \$ | \$ | \$ |
| 8. Transfers | \$ | \$ | \$ |
| 9. Total Expenditures/Outlays or Obligations | \$ | \$ | \$ |
| 10. Awarded | | | \$ |
| 11. Unobligated Balance | | | \$ |
| | | | QUARTERLY ESTIMATE |
| 12. Federal Funds Requested for Next Qtr. Ended | | | \$ |
| | | | MAINTENANCE OF EFFORT |
| 13. State Financial Participation (MOE) | | | \$ |

| | that the State's share of expenditures estimated is or will be | | |
|---------------------------|--|--------------------------------|----------------------|
| Signature: State Official | | Typed Name, Title, Agency Name | |
| Date Submitted: | | | For Federal Use Only |
| | Page 1 of 1 Approved OMB No. xx | xxx-xxxx Form ACF-196 (xx/xx) | |



Department of Health and Human Services

Administration for Children and Families

Temporary Assistance for Needy Families (TANF) ACF - 196 Financial Report

| State | Fiscal Year | Current Quarter Ended | Next Quarter Ending | Award Reconciliation [] YES [] NO | |
|--|---------------------------------|-------------------------------------|--|---|--|
| | Federal Funds | State | Funds | Contingency Funds | ARRA TANF Funds |
| | FEDERAL AWARDS & TRANSFERS | | | Federal Share at FMAP Rate of: | FEDERAL SHARE AT FMAP RATE OF: % |
| | (A) | (B) | (C) | (D) | (E) |
| 1. Awarded | \$ | | | \$ | \$ |
| 2. Transferred to CCDF Discretionary | \$ | | | | |
| 3. Transferred to SSBG | \$ | | | | |
| 4. Adjusted SFAG Expenditures Categories | FEDERAL TANF | STATE MOE EXPENDITURES IN TANF | MOE EXPENDITURES SEPARATE STATE PROGRAMS | FEDERAL EXPENDITURES | FEDERAL EXPENDITURES |
| 5. Expenditures On Assistance | \$ | \$ | \$ | \$ | \$ |
| a. Basic Assistance | \$ | \$ | \$ | \$ | \$ |
| b. Child Care | \$ | \$ | \$ | \$ | \$ |
| c. Transportation and Other Supportive Services | \$ | \$ | \$ | \$ | \$ |
| d. Assistance Authorized Solely under Prior Law | \$ | \$ | \$ | \$ | \$ |
| 6. Expenditures on Non-Assistance | \$ | \$ | \$ | \$ | \$ |
| a. Work Related Activities / Expenses | \$ | \$ | \$ | \$ | \$ |
| 1. Work Subsidies | \$ | \$ | \$ | \$ | \$ |
| 2. Education and Training | \$ | \$ | \$ | \$ | \$ |
| 3. Other Work Activities / Expenses | \$ | \$ | \$ | \$ | \$ |
| b. Child Care | \$ | \$ | \$ | \$ | \$ |
| c. Transportation | \$ | \$ | \$ | \$ | \$ |
| 1. Job Access | \$ | \$ | \$ | \$ | \$ |
| 2. Other | \$ | \$ | \$ | \$ | \$ |
| d. Individual Development Accounts | \$ | \$ | \$ | \$ | \$ |
| e. Refundable Earned Income Tax Credits | \$ | \$ | \$ | \$ | \$ |
| f. Other Refundable Tax Credits | \$ | \$ | \$ | \$ | \$ |
| g. Non-Recurrent Short Term Benefits | \$ | \$ | \$ | \$ | \$ |
| h. Prevention of Out-of-Wedlock Pregnancies | \$ | \$ | \$ | \$ | \$ |
| i. 2-Parent Family Formation and Maintenance | \$ | \$ | \$ | \$ | \$ |
| j. Administration | \$ | \$ | \$ | \$ | \$ |
| k. Systems | \$ | \$ | \$ | \$ | \$ |
| I. Non-Assistance Authorized Solely Under Prior Law | \$ | \$ | \$ | \$ | \$ |
| m. Other | \$ | \$ | \$ | \$ | \$ |
| 7. Total Expenditures | \$ | \$ | \$ | \$ | \$ |
| 8. Transitional Services for Employed | | | | | |
| 9. Federal Unliquidated Obligations | \$ | \$ | \$ | \$ | \$ |
| 10. Unobligated Balance | \$ | \$ | \$ | \$ | \$ |
| 11. State Replacement Funds | | \$ | | | |
| Quarterly Estimate | TANF Federal Funds | | | | |
| 12. Estimate for Next QTR. Ended | \$ | | | | |
| THIS IS TO CERTIFY THA SIGNATURE: AUTHORIZED STATE OFFICIAL | T THE INFORMATION REPORTED ON A | L PARTS OF THIS FORM IS ACCURATE AN | D TRUE TO THE BEST OF MY KNOWLED | GE AND BELIEF. TYPED NAME, TITLE, AGENC | YNAME |

| DATE SUBMITTED: | SUBMITTAL: | [] NEW [|] REVISED | ſ |] FINAL |
|--|--------------|-----------|-----------|---|---------|
| PAGE 1 OF 1 APPROVED OMB No 0970-0247 expires xx/xx/xxxx | FORM ACF-196 | | | | |