Attn: Program Director

Three County Continuum of Care

Community Action Pioneer Valley

393 Main Street, Greenfield, MA 01301

RE: **(PERFORMANCE PERIOD)** **Expense Reimbursement Request**

Sub recipient: **(AGENCY NAME)**

Project: **(NAME OF COC-FUNDED PROJECT)**

Grant No.: **(YOUR GRANT # STARTING WITH MA-)**

Performance Period: **(PERIOD YOU ARE REQUESTING REIMBURSEMENT FOR)**

Total Amount Requested: **(TOTAL EXPENSE REQUEST AMOUNT)**

Dear Program Director,

This letter is to confirm that I have reviewed and approved as accurate the attached Expense Reimbursement Request for the period and project specified above.

Sincerely,

***(Signature)***

**(FISCAL CONTACT NAME)**

**(TITLE)**