# CORONERS

## 1. Summary of Chapter 498/77

Under prior law, the coroner inquires into and determined the circumstances, manner, and cause of certain specified types of human deaths. It allowed the coroner to determine the extent of inquiry into deaths occurring under natural circumstances, and allowed the coroner, under certain circumstances, to authorize the physician of record to sign the death certificate.

Chapter 498, Statutes of 1977, amended Section 27491 of the Government Code, would additionally require the coroner to perform an inquiry into deaths occurring under natural circumstances whenever a patient dies in a hospital serving the mentally disabled under the State Department of Mental Health. This section was further amended by Chapter 69, Statutes of 1978 to include the coroner inquiries into patient deaths in state hospitals, serving the developmentally disabled, that are operated by the State Department of Developmental Services.

## 2. Eligible Claimants

Any county incurring increased costs as a result of this mandate is eligible to claim reimbursement of those costs.

## 3. Appropriations

Claims may only be filed with the State Controller's Office for programs that have been funded in the State Budget Act or in special legislation. To determine if current funding is available for this program, refer to the schedule "Appropriations for State Mandated Cost Programs" presented in the "Annual Claiming Instructions for State Mandated Costs" issued in mid-September for each year to the county auditor's office.

## 4. Types of Claims

### A. Entitlement Claims

This program has been included in the State Mandates Apportionment System (SMAS). The SMAS is a process where a claimant receives an annual apportionment, reflective of the program's costs. A claimant is eligible to be included in the SMAS after having established a base year entitlement for the program. The State Controller's Office determines a base year entitlement by averaging the claimant's actual costs for any three consecutive fiscal years. The actual costs are first adjusted according to any change in the implicit price deflator. With an established base year entitlement, no further claims need to be filed. Claimant will receive annually, by November 30, an apportionment adjusted for any change in the implicit price deflator.

A claimant with no base year entitlement may begin submitting reimbursement claims for a minimum of three consecutive fiscal years or entitlement claims covering the preceding three consecutive fiscal years. The three consecutive fiscal years of costs can be a combination of entitlement and reimbursement claims. There is no statutory deadline for filing entitlement claims. However, entitlement claims and supporting documents should be filed by November 30 to permit an orderly processing of claims. When the claims are approved and a base year entitlement amount is determined, the claimant will receive an apportionment reflective of the program's current year costs. Entitlement claims are only for the purpose of establishing a base year entitlement and not to be used for claiming of reimbursement.

### B. Reimbursement and Estimated Claims

A claimant may file a reimbursement claim and/or an estimated claim. A reimbursement claim detail the costs actually incurred for the previous fiscal year. An estimated claim shows the costs to be incurred for the current fiscal year. A claim for reimbursement or an estimate must exceed $200 per program per fiscal year.

**C. Filing Deadline**

Refer to item 3 "Appropriations" to determine if the program is funded for the current fiscal year. If funding is available, an estimated claim may be filed.

(1) An estimated claim must be filed with the State Controller's Office and postmarked by January 15 of the fiscal year in which costs are to be incurred. Timely filed estimated claims will be paid before late claims.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by January 15 following the fiscal year in which costs were incurred. If the claim is filed after the deadline, but by January 15 of the succeeding fiscal year the approved claim will be reduced by a late penalty of 10% but not to exceed $1,000. If the claim is filed more than one year after the deadline, the claim cannot be accepted.

If a local agency received payment for an estimated claim, a reimbursement claim must be filed by January 15 regardless if the amount received was more or less than the actual costs. If the agency fails to file a reimbursement claim, monies received must be returned to the State. If no estimated claim was filed, the agency may file a reimbursement claim by November 30 detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. See item 3 above.

**5. Reimbursement**

Eligible claimants will be reimbursed for the added costs of the county coroner’s inquiry into deaths caused by natural circumstances in state hospitals operated by the State Department of Mental Health and State Department of Developmental Services.

**6. Reimbursement Limitations**

Any offsetting savings or reimbursement the claimant received from any source, as a result to this mandate, must be deducted from the amount claimed.

Investigative functions normally performed by other law enforcement agencies are not reimbursable.

**7. Claiming Forms and Instructions**

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer-generated report in substitution for forms CO-1 and CO-2, provided the format of the report and data fields

**A. Form CO-2, Component/Activity Cost Detail**

This form is used to segregate the detail costs by claim component. A separate form CO-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual number of hours devoted to each function, the productive hourly rate, and the related fringe benefits.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on the mandate.

(2) Office Supplies

Only expenditures that can be identified as a direct cost of the mandate can be claimed. List cost of materials that have been consumed or expended specifically for the purpose of this mandate.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders, and other documents evidencing the validity of the expenditures.

(3) Travel

Travel expenses for mileage, per diem, lodging and other employee entitlement are reimbursable in accordance with the rules of the local jurisdiction. Give the name(s) of the traveler(s), purpose of the trip, inclusive travel dates, destination points and costs.

Source documents required to be maintained by the claimant may include, but are not limited to, receipts, employee's travel expense claims and other documents evidencing the validity of the expenditures.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office upon request.

**B. Form CO-1, Claim Summary**

This form is used to summarize direct costs by claim component and compute allowable indirect costs for the mandate. Claim statistics shall identify the amount of work performed during the claim period for which costs are claimed. The claimant must show the number of deaths caused by natural circumstances that were investigated. Direct costs on this form are brought forward from form CO-2.

Indirect costs may be computed as 10% of direct labor, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have their own ICRP.

**C. Form FAM-27, Claim for Payment**

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form CO-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

**D. Form FAM-43, Entitlement Claim**

This form is used to certify the actual costs incurred for a fiscal year for the purpose of establishing a base year entitlement. No payment is made for an entitlement claim.

# CLAIM FOR PAYMENT
## Pursuant to Government Code Section 17561
## CORONERS

| For State Controller Use Only | Program |
|---|---|
| (19) Program Number 00088 | 088 |
| (20) Date Filed ____/____/____ | |
| (21) LRS Input ____/____/____ | |

LABEL HERE

(01) Claimant Identification Number

(02) Claimant Name

County of Location

Street Address or P.O. Box | Suite

City | State | Zip Code

| Reimbursement Claim Data | |
|---|---|
| (22) CO-1, (03) | |
| (23) CO-1, (04)(d) | |
| (24) CO-1, (05) | |
| (25) CO-1, (06) | |
| (26) CO-1, (08) | |
| (27) CO-1, (09) | |
| (28) | |
| (29) | |
| (30) | |
| (31) | |
| (32) | |
| (33) | |
| (34) | |
| (35) | |
| (36) | |

| Type of Claim | Estimated Claim | Reimbursement Claim |
|---|---|---|
| | (03) Estimated ☐ | (09) Reimbursement ☐ |
| | (04) Combined ☐ | (10) Combined ☐ |
| | (05) Amended ☐ | (11) Amended ☐ |
| **Fiscal Year of Cost** | (06) **20___/20___** | (12) **20___/20___** |
| **Total Claimed Amount** | (07) | (13) |
| Less: **10% Late Penalty, not to exceed $1,000** | | (14) |
| Less: **Prior Claim Payment Received** | | (15) |
| **Net Claimed Amount** | | (16) |
| **Due from State** | (08) | (17) |
| **Due to State** | | (18) |

## (37) CERTIFICATION OF CLAIM

**In accordance with the provisions of Government Code §17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.**

**I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.**

**The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.**

Signature of Authorized Officer | Date

Type or Print Name | Title

(38) Name of Contact Person for Claim

Telephone Number ( ) - Ext.

E-Mail Address

| Program 088 | CORONERS<br>Certification Claim Form<br>Instructions | FORM FAM-27 |
|---|---|---|

(01) Enter the payee number assigned by the State Controller's Office.

(02) Enter your Official Name, County of Location, Street or P.O. Box Address, City, State, and Zip Code.

(03) If filing an estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing a combined estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended estimated claim, enter an "X" in the box on line (05) Amended.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of the estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CO-1 and enter the amount from line (10). If more than one form is completed due to multiple department involvement in this mandate, add line (10) of each form.

(08) Enter the same amount as shown on line (07).

(09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing a combined reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended reimbursement claim, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of the reimbursement claim from form CO-1, line (10). The total claimed amount must exceed $1,000.

(14) Reimbursement claims must be filed by January 15 of the following fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter zero if the claim was timely filed, otherwise, enter the product of multiplying line (13) by the factor 0.10 (10% penalty), or $1,000, whichever is less.

(15) If filing a reimbursement claim and a claim was previously filed for the same fiscal year, enter the amount received for the claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.

(18) If line (16), Net Claimed Amount, is negative, enter that amount on line (18), Due to State.

(19) to (21) Leave blank.

(22) to (36) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g., CO-1, (03), means the information is located on form CO-1, block (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 35.19% should be shown as 35. **Completion of this data block will expedite the payment process**.

(37) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer, and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by an original signed certification**. **(To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

(38) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

**SUBMIT A SIGNED ORIGINAL, AND A COPY OF FORM FAM-27, WITH ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:**

***Address, if delivered by U.S. Postal Service:***

**OFFICE OF THE STATE CONTROLLER**
**ATTN: Local Reimbursements Section**
**Division of Accounting and Reporting**
**P.O. Box 942850**
**Sacramento, CA 94250**

***Address, if delivered by other delivery service:***

**OFFICE OF THE STATE CONTROLLER**
**ATTN: Local Reimbursements Section**
**Division of Accounting and Reporting**
**3301 C Street, Suite 500**
**Sacramento, CA 95816**

# CLAIM FOR PAYMENT
## Pursuant to Government Code Section 17561
## CORONERS

For State Controller Use Only

(19) Program Number 088
(20) Date Filed _____/_____/_____
(21) LRS Input _____/_____/_____

**Program 088**

LABEL HERE

| | |
|---|---|
| (01) Claimant Identification Number | |
| (02) Mailing Address | |
| Claimant Name | |
| County of Location | |
| Street Address or P.O. Box | |
| City State Zip Code | |

| Entitlement Claim | |
|---|---|
| (15) CO-1, (03) | |
| (16) CO-1, (04)(d) | |
| (17) CO-1, (05) | |
| (18) CO-1, (06) | |
| (19) CO-1, (08) | |
| (20) CO-1, (09) | |
| (21) | |
| (22) | |
| (23) | |
| (24) | |
| (25) | |
| (26) | |
| (27) | |
| (28) | |
| (29) | |
| (30) | |

| Base Year | Fiscal Years | FAM-27 | Amount |
|---|---|---|---|
| First | (03) | (06) ☐ | (09) |
| Second | (04) | (07) ☐ | (10) |
| Third | (05) | (08) ☐ | (11) |

## (31) CERTIFICATION OF CLAIM

**In accordance with the provisions of Government Code §17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.**

**I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.**

**The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.**

Signature of Authorized Officer _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____

Telephone Number (_____) _____ - _____ Ext. _____

E-mail Address _____

| Program 088 | CORONERS<br>Certification Claim Form<br>Instructions | FORM FAM-43 |
|---|---|---|

NOTE: Chapter 1534, Statutes of 1985, established the State Mandates Apportionment System (SMAS), a method of paying designated mandated programs as apportionments. This program is included in the SMAS. A claimant who has established a base year entitlement for this program will receive an annual payment by January 15 from the State Controller's Office. A base year entitlement is determined for each district by averaging their approved claims, (i.e., actual costs) 1981-82, 1982-83, and 1983-84 fiscal years or any three consecutive fiscal years thereafter. If a claimant has incurred costs for three consecutive fiscal years, but has not filed a claim for each of those years, the claimant may file an entitlement claim with the State Controller's Office. An entitlement claim is filed solely for the purpose of establishing a base year cost and may be filed for any or all of the three fiscal years. Once a base year entitlement has been established, no additional claim need to be filed by the claimant. Submit a separate form FAM-43 for each fiscal year that is needed to complete the three consecutive fiscal years.

(01) Enter the payee number assigned by the State Controller's Office.

(02) Enter your Official Name, County of Location, Street or P.O. Box Address, City, State, and Zip Code.

(03) to (05) Enter the three consecutive fiscal years that comprise the base year.

(06) to (08) If a form FAM-27 was filed for any fiscal year, enter an "x" in the box for that fiscal year.

(09) to (11) Enter the amount from form CO-1, line (12) that corresponds to the fiscal year for this Entitlement Claim. Only one amount should appear on lines (09) through (11). Complete a separate FAM-43 for each entitlement claim. Do not enter an amount for the fiscal year in which a FAM-27 was previously filed as indicated in the checked box.

(12) to (14) Leave blank.

(15) to (30) Bring forward cost information as specified on the left-hand column of lines (15) through (17) for the reimbursement , e.g., CO-1, (03), means the information is located on form CO-1, line (03). Enter the information in the left-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number without the percent symbol (i.e., 34.548% should be shown as 35). Completion of this data block will expedite the payment process.

(31) Read the statement entitled "Certification of Claim". If the statement is true, the claim must be dated, signed by the entity's authorized officer and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by an original signed cerification. (To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

(32) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

**SUBMIT A SIGNED ORIGINAL, AND A COPY OF FORM FAM-27, WITH ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:**

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

| Program 088 | MANDATED COSTS<br>CORONERS<br>CLAIM SUMMARY | FORM CO-1 |
|---|---|---|

| (01) Claimant | (02) Type of Claim | | Fiscal Year |
|---|---|---|---|
| | Reimbursement | ☐ | |
| | Estimated | ☐ | 20___/20___ |
| | Entitlement | ☐ | |

**Claim Statistics**

| | |
|---|---|
| (03) Number of deaths caused by natural circumstances | |

| **Direct Costs** | **Object Accounts** | | | |
|---|---|---|---|---|
| (04) Reimbursable Component | (a) Salaries | (b) Benefits | (c) Services and Supplies | (d) Total |
| Inquiry into naturally occurring deaths | | | | |

**Indirect Costs**

| | | |
|---|---|---|
| (05) Indirect Cost Rate | [From ICRP] | % |
| (06) Total Indirect Costs | [Line (05) x line (04)(a)] or [line (05) x {line (04)(a) + line (04)(b)}] | |
| (07) Total Direct and Indirect Costs | [Line (04)(d) + line (06)] | |

**Cost Reduction**

| | |
|---|---|
| (08) Less: Offsetting Savings, if applicable | |
| (09) Less: Other Reimbursements, if applicable | |
| (10) Total Claimed Amount [Line (07) - {line (08) + line (09)}] | |

| Program 088 | CORONERS CLAIM SUMMARY Instructions | FORM CO-1 |
|---|---|---|

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement, Estimated, or Entitlement , to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form CO-1 must be filed for a reimbursement claim. Do not complete form CO-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form CO-1 must be completed and a statement attached explaining the increased costs. Without this information the estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Enter the number of deaths caused by natural circumstances which were investigated.

(04) Reimbursable Components. For each reimbursable component, enter the total from form CO-2, line (05), columns (d), (e), and (f) to form CO-1, block (04), columns (a), (b), and (c) in the appropriate row. Total each row.

(05) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, without preparing an ICRP. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim.

(06) Total Indirect Costs. If the 10% flat rate is used for indirect costs, multiply Total Salaries, line (04)(a), by the Indirect Cost Rate, line (05). If an ICRP is submitted and both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (04)(a), and Total Benefits, line (04)(b), by the Indirect Cost Rate, line (05). If more than one department is reporting costs, each must have its own ICRP for the program.

(07) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (04)(d), and Total Indirect Costs, line (06).

(08) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(09) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(10) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (08), and Other Reimbursements, line (09), from Total Direct and Indirect Costs, line (07). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

| Program 088 | MANDATED COSTS<br>CORONERS<br>COMPONENT/ACTIVITY COST DETAIL | FORM CO-2 |
|---|---|---|

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Inquiry into naturally occurring deaths

(04) Description of Expenses: Complete columns (a) through (f).

| (a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses | (b) Hourly Rate or Unit Cost | (c) Hours Worked or Quantity | Object Accounts (d) Salaries | (e) Benefits | (f) Services and Supplies |
|---|---|---|---|---|---|
| | | | | | |
| (05) Total ☐ Subtotal ☐ Page:____of____ | | | | | |

| Program 088 | CORONERS<br>COMPONENT/ACTIVITY COST DETAIL<br>Instructions | FORM CO-2 |
|---|---|---|

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred. Do not file form CO-2 for an Estimated Claim.

(03) Reimbursable Component. Inquiry into naturally occurring deaths. This line identifies the costs which may be claimed on form CO-2.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services, travel expenses, etc. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated and no payment was made at the time the claim was filed, the time for the Controller to initiate an audit shall be from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

| Object/ Sub object Accounts | Columns | | | | | | Submit these supporting documents with the claim |
|---|---|---|---|---|---|---|---|
| | (a) | (b) | (c) | (d) | (e) | (f) | |
| **Salaries** | Employee Name | Hourly Rate | Hours Worked | Salaries = Hourly Rate x Hours Worked | | | |
| **Benefits** | Title<br>Activities | Benefit Rate | | Salaries | Benefits = Benefit Rate x Salaries | | |
| **Services and Supplies**<br>**Office Supplies** | Description of Supplies Used | Unit Cost | Quantity Used | | | Cost = Unit Cost x Quantity Used | |
| **Contract Services** | Name of Contractor<br>Specific Tasks Performed | Hourly Rate | Hours Worked<br>Inclusive Dates of Service | | | Cost = Hourly Rate x Hours Worked | |
| **Travel** | Purpose of Trip<br>Name and Title<br>Departure and Return Date | Per Diem Rate<br>Mileage Rate<br>Travel Cost | Days<br>Miles<br>Travel Mode | | | Total Travel Cost = Rate x Days or Miles | |

(05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form CO-1, block (04), columns (a), (b), and (c) in the appropriate row.