HOMICIDE TRIALS CLAIM FOR PAYMENT	For State Controller Use Only Date Filed:	PROGRAM **031**

(01) Claimant Identification Number

(02) County Name

County of Trial Location

Street Address or P.O. Box

City State Zip Code

Type of Claim

(03) Actual Costs Reimbursement/Final Reconciliation (GC section 15202) ☐

(04) Change of Venue (GC section 15202.1) ☐

(05) Advance Payment (GC section 11019.5) ☐

(06) Amended ☐

Fiscal Year Or Claim Period	(07) 20___ / ___ to 20___ / ___
Total Claimed Amount	(08)
Less: Prior Claim Payment Received	(09)
Due from State	(10)
Due to State	(11)

(12) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code (GC) sections 15202, 15202.1, and 11019.5, I certify that I am the officer authorized by the county to file 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 GC sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grants or payments received for reimbursement of costs claimed herein. All costs claimed are supported by source documentation currently maintained by the claimant.

The amount for this reimbursement is hereby claimed from the State for payment of actual costs or estimated advance 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 Signed _____

_____ Telephone Number _____

_____ Email Address _____

Type or Print Name and Title of Authorized Signatory

(13) Name of Contact Person for Claim Telephone Number _____

_____ Email Address _____

PROGRAM 031	HOMICIDE TRIALS CLAIM FOR PAYMENT INSTRUCTIONS	FORM FAM-45

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

(02) Enter the county name, county of trial location, street or postal office box address, city, state, and zip code.

(03) If filing a reimbursement or final reconciliation claim under Government Code (GC) section 15202, enter an "X" in the box on line (03), Actual Cost Reimbursement/Final Reconciliation.

(04) If filing a change of venue reimbursement claim under GC section 15202.1, enter an "X" in the box on line (04), Change of Venue.

(05) If filing an advance payment claim under GC section 11019.5, enter an "X" in the box on line (05), Advance Payment.

(06) For amended claims, please see below:

- If filing an amended Actual Costs Reimbursement/Final Reconciliation claim, enter an "X" in the box on lines (03) and (06).
- If filing an amended Change of Venue claim, enter an "X" in the box on lines (04) and (06).

(07) Actual Costs Reimbursement/Final Reconciliation Claims or Change of Venue: Enter the fiscal year (FY) in which costs were incurred. If costs for more than one FY are being claimed, complete a separate Form FAM-45 for each FY.

Advance Payment Claims: Enter the FY in which costs are expected to be incurred.

(08) Enter the total claimed amount from Form 1B, line (12) or line (17).

(09) Actual Costs Reimbursement/Final Reconciliation Claims or Change of Venue: If a claim was previously filed for the same FY or claim period, enter the amount received for the claim. Claim amounts should be rounded to the nearest dollar. If no amount was received, enter zero.

Advance Payment Claims: Enter the amount the county received for advance payments from Form 1A, line (08). Claim amounts should be rounded to the nearest dollar. If no advance payments were received, enter zero.

(10) Actual Costs Reimbursement/Final Reconciliation Claims or Change of Venue: Enter the difference between line (08) and line (09) if the balance is positive. Negative balances must be entered on line (11). Claim amounts should be rounded to the nearest dollar.

Advance Payment Claims: Enter the Adjusted Net Advance Payment from Form 1A, line (10) if the balance is positive. Negative balances must be entered on line (11). Claim amounts should be rounded to the nearest dollar.

(11) Actual Costs Reimbursement/Final Reconciliation Claims or Change of Venue: Enter the difference between line (08) and line (09) if the balance is negative.

Advance Payment Claims: Enter the Adjusted Net Advance Payment from Form 1A, line (10) if the balance is negative.

Payments Due to the State as a result of negative balances:

Please make your checks payable to the State Controller's Office, and notate on the check, "For Local Reimbursements Section – Homicide Trial Costs".

Remit your payments with a copy of the claim to:

State Controller's Office
Attention: Departmental Accounting
P.O. Box 942850
Sacramento, CA 94250-5875

(12) Read the statement of Certification of Claim. The claim must be signed and dated by the agency's authorized officer; type or print name and title, telephone number, and email address. **Claims cannot be paid unless accompanied by an original signed certification. (Please sign the Form FAM-45 in blue ink and attach a copy to the top of the claim package.)**

(13) Enter the name, telephone number, and email address of the agency contact person for the claim.

Submit a signed original and one copy of Form FAM-45 in addition to two copies of all supporting documentation to:

If delivered by U.S. Postal Service:

Office of the State Controller
Attn: Local Reimbursements Section
Local Government Programs and Services Division
P.O. Box 942850
Sacramento, CA 94250

If delivered by other delivery service:

Office of the State Controller
Attn: Local Reimbursements Section
Local Government Programs and Services Division
3301 C Street, Suite 700
Sacramento, CA 95816

Contact Information:
Questions? Contact the Controller's Team at (916) 324-5729 or LRSLGPSD@sco.ca.gov.