

NOTICE: EVERY PERSON WHO, WITH INTENT TO DEFRAUD, PRESENTS FOR ALLOWANCE OR FOR PAYMENT TO ANY STATE BOARD OR OFFICER . . . AUTHORIZED TO ALLOW OR PAY THE SAME IF GENUINE, ANY FALSE OR FRAUDULENT CLAIM, BILL, ACCOUNT, VOUCHER, OR WRITING, IS GUILTY OF A CRIME (PENAL CODE SECTION 72).

See the instructions on the reverse side before completing this form.

STATE AGENCY NAME	AGENCY CODE	TOTAL NUMBER AND AMOUNT
		\$
MAILING ADDRESS		
DEBTOR(S) NAME(S)	DEFICIENT FUND OR ACCOUNT (<i>Specific title</i>)	
	BUDGET ACT ITEM FROM WHICH TO PAY CLAIM	

EXPLANATION OF FACTS (*Including date, place and complete circumstances*)

CORRECTIVE ACTIONS TAKEN

SUMMARY OF SHORTAGE
(Please mark appropriate boxes)

<input type="checkbox"/> Shortage result of uncollectible account receivable	<input type="checkbox"/> Shortage result of theft
<input type="checkbox"/> Account receivable collection procedures were utilized (SAM 8293.1 - 8293.2)	<input type="checkbox"/> Police report
<input type="checkbox"/> Attempt made to offset receivable against money owed to person or entity (SAM 8293.4)	<input type="checkbox"/> Custodian used due diligence and followed good practices in handling and safeguarding the money
<input type="checkbox"/> Checkout procedure for separating employees (SAM 8580.4)	<input type="checkbox"/> Cash shortage did not result from employee's dishonesty, carelessness or negligence
<input type="checkbox"/> Receivable is a salary/travel advance for a former State employee	<input type="checkbox"/> Shortage result of clerical error (<i>Note that explanation must be signed by the person responsible for the error</i>)
<input type="checkbox"/> Shortage result of SCO claim correction. (Explanation required.)	<input type="checkbox"/> Copy of original check (<i>both sides</i>) is attached (<i>Note that a copy of the check is required by the State Controller's Office for all claims.</i>)
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Based on internal audit unit review, the above information is accurate and complete.

INTERNAL AUDIT CHIEF (<i>Signature and Title</i>)	DATE SIGNED		
<i>I hereby certify under penalty of perjury as follows: That the services and procedures mentioned herein were actually rendered or performed. All information provided is true and correct.</i>			
CHIEF ACCOUNTING OFFICER (<i>Signature and Title</i>)	DATE SIGNED	TELEPHONE NUMBER	EMAIL ADDRESS

CLAIM FOR REIMBURSEMENT

STD 27A (Rev. 5/2024) (REVERSE)

INSTRUCTIONS

This form must be completed with ***all*** of the required information. Please refer to State Administrative Manual Section 8150.2 for further information of submission.

Use this form only for the proposed replenishment of a cash deficiency in an established fund balance (e.g. office revolving emergency purchase fund, or cashier's change fund).

For uncollectible accounts receivable, use form STD 27, Discharge From Accountability, refer to State Administrative Manual Section 8293.5 and submit the form to the STATE CONTROLLER'S OFFICE. and submit the form to the STATE CONTROLLER'S OFFICE.

For an individual deficiency (shortage) of \$1,000 or more, or for a multiple deficiencies claim schedule which totals \$2,500 or more, submit this form to OSAEReports@dof.ca.gov or by mail to:

Department of Finance
ORF Reimbursement
Office of State Audits and
Evaluations 915 L Street, 6th Floor
Sacramento, CA 95814-4998
IMS Code A-15
(916) 322-2985 or CALNET 492-2985

For an individual deficiency (shortage) of less than \$1,000, or for a multiple deficiencies claim schedule which totals \$2,499.99 or less, agencies are delegated the authority to submit the Claim for Reimbursement directly to SCO.