South Carolina Lieutenant Governor - Office on Aging

Agency Name:	EXPERIENCE WORKS
LGOA GRANT Number:	EWDOL14
Grant Period:	JULY 1, 2014 THROUGH JUNE 30, 2015
Final -	**Indicate One** YES (NO)
Payment #:	8
Payment Period:	OCTOBER 31, 2014 THROUGH NOVEMBER 1, 2014
Payment Request Prepared by: ANDREW JAIME	**Phone: 703-682-2535**

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM - TITLE V

		5B80 EW&F Federal (a)	5B81 OPC Federal (b)	5B82 ADM Federal (c)	5B83 MATCH Local (d)
A	Current Grant Award	$408,447.00	$69,133.00	$51,971.00	$58,839.00
B	Actual Expenses Year To Date	$144,703.02	$16,356.88	$12,035.44	$32,529.47
C	Prior Funds Requested Year to Date	$127,894.70	$16,356.88	$12,035.44	$26,168.57
D	Reimbursement Needed (Line B minus Line C)	$16,808.32	$0.00	$0.00	$6,360.90
E	Federal Share (Line D) 100%	$16,808.32	$0.00	$0.00	
F	Local Share (Line D) 100%				$6,360.90
G	Year to Date Award Balance (A)-(C)-(D)	$263,743.98	$52,776.12	$39,935.56	$26,309.53
H	**TOTAL TO BE PAID BY GRANT ACTIVITY (Line E)**	**$16,808.32**	**$0.00**	**$0.00**	
I	**TOTAL PAYMENT Line H ((a) + (b) + (c))**	**$16,808.32**			

Please sign, scan and e-mail Payment Requests to financehelp@aging.sc.gov

Under the penalties for perjury under State Law, I certify that this report is accurate and complete to the best of my knowledge and belief.

Signature: [signature]

Title: INTERIM STATE PROGRAM MANAGER

Date: 11/17/14	Phone: 703-682-2273	FAX: 803-252-9155

SOUTH CAROLINA STATE TITLE 5
REPORT OF CERTIFIED OR IN-KIND COSTS

SECTION I COMPLETED BY CONTRACTOR

For the period

THRU NOVEMBER

Experience Works, Inc.
Name of Contractor

_____
Program Officer, DHR

Accounting Services, DHR

Certified Cost In-Kind Cost

Community Cost Sharing
(Certified Cash Transfer (CCT)

TITLE OF PROGRAM: SCSEP

CONTRACT # EWDOL14 **IDENTIFICATION #** _____ **CONTROL #** _____

NAME AND ADDRESS OF PROVIDER OR CERTIFIED OR IN-KIND COSTS:

Experience Works, Inc.
P O Box 2768
Richmond Hill, Georgia 31324

COSTS:

PERSONNEL (attach continuation, if needed)

NAME	TITLE	SALARY	FRINGE BENEFITS	%TIME	APPLICABLE AMOUNT
Host Agency	Supv.	X			$ 6,360.90
SUB-TOTAL					$ 6,360.90
OTHER COSTS (attach continuation, if needed)					

SUB-TOTAL.....$ 6,360.90
GRAND TOTAL.....$ 6,360.90

I, the undersigned, hereby certify that the above certified or in-kind match costs have been provided/received in compliance with the requirements and conditions of the applicable federal program. I further certify that my office has available a set of accounting records relative to these certified costs that specifically identifies each specific detailed transaction direct to this federal program and that these records are available for DHR or federal auditors review.

Date: 11/17/14 Signed: Sheila Earp

INTERIM STATE PROGRAM MANAGER_____
Title

Form 5215