APPENDIX

Date _____

REQUISITION BLANK

No. _____

PLEASE FURNISH AND DELIVER TO _____ AT _____

BUILDING THE FOLLOWING ITEMS TO BE USED FOR _____

Prescribed by State Board of Accounts Form No. 500

QUANTITY OR UNIT		DESCRIPTION	UNIT	CHARGES	
ORDERED	DELIV'D		PRICE	AMOUNT	ACCT. NO.

AUTHORIZED BY	ORDERED BY	GOODS RECEIVED BY

EXHIBIT A

EXHIBIT B

PRESCRIBED BY STATE BOARD OF ACCOUNTS — GENERAL FORM NO. 98 (REV. 1998)

PURCHASE ORDER

NOTE: NO CLAIM WILL BE APPROVED FOR PAYMENT UNLESS ORIGINAL COPY OF THIS ORDER OR THE P.O. NUMBER IS MADE A PART OF THE CLAIM.

GOVERNMENTAL UNIT

ADDRESS

P.O. NO.

This Number must be on Invoice, Claim, and Delivery Memos.

TO

DATE

ADDRESS

REQ.

CITY

IN ACCORDANCE WITH BID AND CONTRACT DATED

SHIP TO

If subject to discount please indicate on Invoice or Claim.

SHIP VIA

CHARGE TO

APPROPRIATION FOR

APPROPRIATION NUMBER

QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	AMOUNT

TOTAL AMOUNT OF ORDER - - - - $

I HEREBY CERTIFY THAT THERE IS AN UNOBLIGATED BALANCE IN THIS APPROPRIATION SUFFICIENT TO PAY FOR THE ABOVE ORDER

BILLING ON THIS ORDER MUST BE ACCORDING TO PRICES SHOWN ABOVE

ORDER BY

Title

FEDERAL EXCISE TAX EXEMPT

INDIANA RETAIL TAX EXEMPT

CERTIFICATE NO. _____

ORIGINAL - VENDOR'S COPY

Prescribed by State Board of Accounts

School Form No. 523 (2006)

ACCOUNTS PAYABLE VOUCHER

_____ SCHOOL CORPORATION _____, Indiana

An invoice or bill to be properly itemized must show: kind of service, where performed, dates service rendered, by whom, rates per day, number of hours, rate per hour, number of units, price per unit, etc.

Payee	Purchase Order No. _____
	Terms _____
	Date Due _____

Invoice Date	Invoice Number	Description (or note attached invoice(s) or bill(s))	Amount
		Total	

I hereby certify that the attached invoice(s), or bill(s), is (are) true and correct and that the materials or services itemized thereon for which charge is made were ordered and received except _____
_____.

_____, 20____ _____ _____

Signature Title

I hereby certify that the attached invoice(s), or bill(s), is (are) true and correct and I have audited same in accordance with IC 5-11-10-1.6.

_____, 20____ _____

Treasurer

EXHIBIT C
PAGE 1

VOUCHER NO. _____ WARRANT NO. _____

Charge These Appropriation

Account Number	Account Name	Amount
	Total	

PAYEE

We have examined the invoice(s) or bill(s) attached and are approving such invoice(s), bill(s) in the amount of

$_____

APPROVED _____ , 20__

BOARD OF SCHOOL TRUSTEES

Prescribed by State Board of Accounts

General Payroll Form No. 99 (Rev. 2006)

PAYROLL SCHEDULE AND VOUCHER

_____
(Office, Board, Department or Institution)

For Period Beginning _____, 20____ and Ending _____, 20____

NOTE: Total hours or days to be paid shall equal the days or hours worked plus authorized leave to which an employee might be entitled by law and under the leave policies established by the governing body. The "Days Lost" column will apply only to salaried employees (not hourly) not entitled to pay for such days.

Page _____of _____ Pages

_____Fund

					DAYS OR HOURS IN PERIOD										DEDUCTIONS												
									Other Leave											Insurance		Retirement				Amount of Warrant	
	NAME OF EMPLOYEE	Approp. No. or Class Title	Code	Noncash Benefits	Worked	Sick Leave	Vacation Leave	Lost Days	Code	Days Hours	Total Days or Hours To Be Paid	Rate of Pay	Gross Pay	Total	Fed. W/H Tax	Social Security Tax	Medicare Tax	State W/H Tax	County W/H Tax	Code	Amount	Code	Amount			(Gross Pay Less Deductions)	Warrant Number
1.																										
2.																										
3.																										
4.																										
5.																										
6.																										
7.																										
8.																										
9.																										
10.																										
11.																										
12.																										
13.																										
14.																										
15.																										
16.																										
		Totals																								

CODES FOR OTHER LEAVE, INSURANCE AND RETIREMENT

A "Code" column has been provided to describe other leave and insurance and retirement plans. Use appropriate letters or numbers to distinguish each kind or type.

REGULAR TIME AND OVERTIME

Two lines have been provided for each employee to show regular time hours and overtime hours worked and the amount each employee earned for regular time and overtime.

EXHIBIT D
PAGE 1

STATE OF INDIANA, _____ COUN

I, _____ Name

to _____ Agency

_____ Title

hereby certify that I have examined the time record of each employee listed on Pages _____ to _____ of this payroll, that each employee has performed the services for which the salaries or compensation is paid: that to the best of my knowledge and belief no part of the salary or compensation or any employee listed hereon is being divided or paid to any person on account of or by the reason of his employment: that the compensation listed opposite the name of each employee is based upon either statutory or regulatory authority and is justly due each such employee: that the deductions have been authorized for the purpose stated: that this payroll totalling $_____ is correct and has by me been approved.

Basic Pay

Dated _____, 20____

_____ (Signature)

_____ (Official title)

I have examined the within claim and hereby certify as follows:
This is in proper form.
That it is duly authenticated as required by law.
That it is based upon { contract. / statutory authority.
That it is apparently { correct. / incorrect.

_____ Disbursing Officer

CLAIM NO. _____

Warrant No. _____ to _____
(Inclusive)

PAYROLL OF

_____
(Office, Board, Department or Institution)

_____
(Fund)

Total Gross Pay $_____
DEDUCTIONS
Federal W/H Tax $_____
Social Security Tax
Medicare Tax
State W/H Tax
CAGIT
Insurance
Retirement

Net Amount of Warrants $_____

Allowed _____ 20____

In the Sum of $_____

_____
(Board of Commission)

DISTRIBUTION OF EXPENSE

Appropriation or Account Title	Approp. or Acct. No.	Amount
Total Gross Pay		

FILED

_____
Official Title

Prescribed by State Board of Accounts

General Form No. 101 (1955)

MILEAGE CLAIM

_____ TO _____

(GOVERNMENTAL UNIT)

_____ ON ACCOUNT OF APPROPRIATION NO. _____ FOR _____

(OFFICE, BOARD, DEPARTMENT OR INSTITUTION)

DATE 20		FROM POINT	TO POINT	ODOMETER READING+ START	ODOMETER READING+ FINISH	NATURE OF BUSINESS	AUTO MILES TRAVELED	MILEAGE @_____¢ PER MILE	
AUTO LICENSE NO.						TOTALS			

+ODOMETER READING columns are to be used only when distance between points cannot be determined by fixed mileage or official highway map.

Pursuant to the provisions and penalties of Chapter 155, Acts 1953, I hereby certify that the foregoing account is just and correct, that the amount claimed is legally due, after allowing all just credits and that no part of the same has been paid.

Date _____ _____

Claim No. _____ Warrant No. _____

IN FAVOR OF

$_____

On Account of Appropriation No. _____ for

Allowed _____, 20____

In the sum of $_____

(Board or Commission)

FILED

(Official Title)

I have examined the within claim and hereby certify as follows:

That it is in proper form.

That it is duly authenticated as required by law.

That it is based upon statutory authority.

That it is apparently { correct. / incorrect.

Disbursing Officer

I certify that the within bill is true and correct; that the mileage therein itemized and for which charge is made was ordered by me and was necessary to the public business; and that the rate per mile is in accordance with statutes or governing ordinances, except

Prescribed by State Board of Accounts

School Form No. 504 (Revised 2006)

(NAME OF SCHOOL CORPORATION) (Address)

SCHEDULE OF PAYMENTS DUE SCHOOL BUS INDEPENDENT CONTRACTORS
FOR PUPIL TRANSPORTATION

School _________________________

No. of days in period ________ Period from ________________ to ______________, 20__ Date of Checks ____________

Route Number	Name of Contractor	Per Diem Rate	Days Served	Amount of Check	Check Number
Total this page				$	
Total this schedule				$	

STATE OF INDIANA, _____ COUNTY, SS:

I, _____, _____
Name (Title)

of _____ hereby certify that I have
(School Corporation)

examined the service record of each contractor listed on Pages _____ to _____ of this schedule; that each contractor has performed the services for which the compensation is to be paid; that to the best of my knowledge and belief no part of the compensation of any contractor listed hereon is being divided or paid to any other person on account of or by reason of his employment; that the compensation listed opposite the name of each contractor is based upon the contract on file for the route lsited and is justly due each such contractor; that this schedule totaling $_____ is correct and has by me been approved.

Date _____, 20___

_____ (Signature)

_____ (Official Title)

CLAIM NUMBER _____

Check Nos. _____ to _____ (Inclusive)

SCHEDULE OF PAYMENTS DUE SCHOOL
BUS INDEPENDENT CONTRACTORS FOR

_____
(Name of School)

Total amount of checks $_____

I have examined the within claim and hereby certify as follows:
That it is in proper form.
That it is duly authenticated as required by law.
That it is based upon contracts.
That it is apparently { correct. / incorrect.

_____
(Disbursing Officer)

Allowed _____, 20___

In the sum of $_____

_____
(Board or Commission)

(Revised 2006)

ACCOUNTS PAYABLE VOUCHER REGISTER

____
Governmental Unit

____
Agency

NOTES: (1) Use both sides of form if needed. Signatures of governing board should appear only on the final page of each meeting in which accounts payable vouchers are allowed. (2) The Memorandum column is for entering action on accounts payable vouchers if disallowed in whole or in part, if continued to a later meeting of governing board, or for other pertinent information.

For Period _______________, 20__ to ________________, 20___

Page ________ of _________ Pages

Prescribed by State Board or Accounts

General Form No. 364 (1997)

DATE FILED	VOUCHER NUMBER	NAME OF CLAIMANT	OFFICE, DEPARTMENT OR FUND	AMOUNT OF VOUCHER	AMOUNT ALLOWED	CHECK/ WARRANT NUMBER	MEMORANDUM (See Note (2) Above)

	DATE FILED	VOUCHER NUMBER	NAME OF CLAIMANT	OFFICE, DEPARTMENT OR FUND	AMOUNT OF VOUCHER		AMOUNT ALLOWED		CHECK/ WARRANT NUMBER	MEMORANDUM (See Note (2) Above)	

I hereby certify that each of the above listed vouchers and the invoices, or bills attached thereto, are true and correct and I have audited same in accordance with IC 5-11-10-1.6.

_________________________, 20____

Fiscal Officer

ALLOWANCE OF VOUCHERS

(IC 5-11-10-2 permits the governing body to sign the Accounts Payable Voucher Register in lieu of signing each claim the governing body is allowing.)

We have examined the vouchers listed on the forgoing accounts payable voucher register, consisting of ____ pages, and except for vouchers not allowed as shown on the Register such vouchers are allowed in the total amount of $_______________.

Dated this ___________ day of ______________, 20__.

SIGNATURES OF GOVERNING BOARD

FORM PRESCRIBED BY STATE BOARD OF ACCOUNTS

SCHOOL FORM NO. 508 (REV. 2006)

FUND LEDGER
AND
LEDGER OF RECEIPTS

FUND TITLE ____

FUND NUMBER ________________________________

SOURCE OF RECEIPT ________________________________

RECEIPT ACCOUNT NUMBER ____________________

	20__ MO.	DAY	RECEIPT OR CHECK NUMBER	DESCRIPTION	POSTING REFERENCE	RECEIPTS	DISBURSEMENTS	BALANCE	
				TOTALS					

EXHIBIT H

FORM PRESCRIBED BY STATE BOARD OF ACCOUNTS

SCHOOL FORM NO. 512 (REV. 2006)

LEDGER OF
APPROPRIATIONS, ALLOTMENTS, ENCUMBRANCES, DISBURSEMENTS AND BALANCES

FUND TITLE _____ FUND NUMBER_____

FUNCTION _____

EXPENDITURE ACCOUNT TITLE _____ ACCOUNT NUMBER _____

20__ MO. DAY	DESCRIPTION	OBJECT CODE	PURCHASE ORDER NUMBER	√	VALUE OF PURCHASE ORDERS			CHECK NUMBER	APPROPRIATION OR ALLOTMENT		
					ENCUMBERED	LIQUIDATED	OUTSTANDING		AMOUNT	DISBURSEMENTS	BALANCE
	TOTALS										

SAMPLE

EXHIBIT I

Prescribed by State Board of Accounts

City or Town Form No. 212 (Rev. 1975)
General Form No. 361 (Rev. 2006)

TREASURERS DAILY BALANCE OF CASH

		Balance From The Previous Day 1	Receipts For The Day 2	Investments Purchased For The Day 3	Disbursements For The Day 4	Investments Cashed For The Day 5	Balance Close of Day 6
1	Ledger Balance - Cash Funds			xxxxx		xxxxx	
2	Investments From Ledger Funds		xxxxx		xxxxx		
3	Totals						

			Deposits During Day		Warrants Issued During Day		
	NAMES OF DEPOSITORIES	Depository Balances Previous Day 1	Ledger Funds 2	Investments From Deposi-tory Balances Cashed-Cost 3	Ledger Funds 4	Investments From Deposi-tory Balances Purchased-Cost 5	Depository Balances Close of Day 6
4A							
4B							
4C							
4D							
4E							
4F							
4G							
4H							
4I							
4J							
5	Total Depository Balances						

	INVESTMENTS - (Listed by Funds as Shown in Investment Register)	Investment Balances Previous Day 1		Investments Purchased-Cost 3		Investments Cashed-Cost 5	Investment Balances Close of Day 6
6A			xxxxx		xxxxx		
6B			xxxxx		xxxxx		
6C			xxxxx		xxxxx		
6D			xxxxx		xxxxx		
6E			xxxxx		xxxxx		
6F			xxxxx		xxxxx		
6G			xxxxx		xxxxx		
6H			xxxxx		xxxxx		
6I			xxxxx		xxxxx		
6J			xxxxx		xxxxx		
7	Depository Balances Invested		xxxxx		xxxxx		
8	Total Investments		xxxxx		xxxxx		
9	Totals - Depositories and Investments		xxxxx		xxxxx		

EXHIBIT J
PAGE 1

City or Town Form No. 212 (Rev. 1975)

General Form No. 361 (Rev. 2006)

DEPOSITORIES AND INVESTMENTS

DATE _____ 20_____

	Column 1	Column 2	
Cash on Hand Beginning of Day (Line 11, preceding page)		x x x x x	1
Add Receipts for the Day (Line 1, Col. 2, opposite page)		x x x x x	2
Add Investments From Depository Balances - Cashed - Cost (Line 5, Col. 3, opposite page)		x x x x x	3
Totals		x x x x x	4
Deduct Deposits During the Day (Line 5, Col. 2, plus Col. 3, opposite page)		x x x x x	5
Net Cash on Hand for which Accountable		x x x x x	6
Cash on Hand Close of Day (Per Cash Count):			7
Currency	x x x x x		8
Coins	x x x x x		9
Checks and Money Orders	x x x x x		10
Total Cash on Hand Close of Day	x x x x x		11
Deduct Advances for Cash Change Fund (If not included in Ledger Balances)	x x x x x		12
Net Cash on Hand (After Deducting Advances)	x x x x x		13
Add-Depository Balance - Close of Day (Line 5, Col. 6, opposite page)	x x x x x		14
Total Cash on Hand an in Depository	x x x x x		15
Add Cash Under	x x x x x		16
Deduct Cash Over	x x x x x		17
Total	x x x x x		18
Add Investments on Hand Close of Day (Line 8, Col. 6, opposite page)	x x x x x		19
Proof (Must equal Record Balance Close of Day, Line 3, Col. 6)	x x x x x		20
			21
			22
			23
			24
			25
			26
			27
			28
			29
			30
			31
			32
			33
			34
			35
			36
			37
			38

EXHIBIT J
PAGE 2

Prescribed by State Board of Accounts

State Board of Accounts

Store Room Record

Form 513

DATE	ORDER & REQ. NO'S	RECEIPTS		UNIT COST	CODE NO.	DISBURSEMENTS		BALANCE	DATE	ORDER & REQ. NO'S	RECEIPTS		UNIT COST	CODE NO.	DISBURSEMENTS		BALANCE
		QUANTITY	COST			QUANTITY	COST				QUANTITY	COST			QUANTITY	COST	

Unit

Description

Article

EXHIBIT K

FORM PRESCRIBED BY STATE BOARD OF ACCOUNTS

FORM NO. 514 (REV. 2005)

TEACHER'S SERVICE RECORD

SOC. SEC. NO._____

SCHOOL YEAR 20___ - 20___

RETIREMENT NO. _____

SCHOOL CORPORATION _____ COUNTY _____ NAME _____

DATE EMPLOYED _____ CONTRACT $ _____ PER DAY $ _____ ADDRESS _____

SCHOOL CORP. OF LAST EMPLOYMENT _____ ACCUMULATED SICK LEAVE EARNED _____ CREDIT TO DATE (EXCLUDING THIS SCHOOL YEAR) _____

PAY PERIOD ENDING MONTH OR OTHER	DAYS IN PERIOD	DAYS LOST	DAYS WORKED	SICK & QUARANTINE DAYS USED	FAMILY DEATH DAYS USED	PERSONAL OR CIVIC AFFAIRS DAYS USED		GROSS SALARY	BALANCE SICK & QUARANTINE DAYS UNUSED	NAME OF SUBSTITUTE EMPLOYED DURING ABSENCE OF REGULAR TEACHER	NO. OF DAYS EMPLOYED	RATE PER DAY PAID TO SUBSTITUTE	
ACCUMULATED LEAVE BROUGHT FORWARD (BALANCE UNUSED FORMER YEARS) AVAILABLE SICK AND QUARANTINE LEAVE THIS SCHOOL YEAR (INCLUDING NOT TO EXCEED 3 DAYS CREDIT FROM LAST EMPLOYMENT)													
								$				$	
TOTALS								$				$	

ACCUMULATED LEAVE FORWARDED TO NEXT SCHOOL YEAR

EXHIBIT L

Prescribed by the State Board of Accounts

General Payroll Form No. 99A (Rev. 1998)

_____
(Unit)

EMPLOYEE'S SERVICE RECORD

YEAR _____

REMARKS	NAME AS ON SOCIAL SECURITY CARD		EMPLOYEE NUMBER
Workweek Begins: Hour of Day ; Day of Week	(Mr., Mrs., Miss)		
	ADDRESS		ZIP CODE
Basis of Pay: (Hr., Day, Week, Bi-Weekly, Month)			
Date of Birth:	SOC. SEC. NO.	CLASSIFICATION	
Normal Work Schedule *	OFFICE, BOARD OR DEPT.	BEGIN. DATE EMPL.	LEAVE ACCRUAL DATE

	1/16	2/17	3/18	4/19	5/20	6/21	7/22	8/23	9/24	10/25	11/26	12/27	13/28	14/29	15/30	31	REGULAR VACATION LEAVE EARNED	TAKEN	BALANCE	SICK LEAVE EARNED	TAKEN	BALANCE	OTHER LEAVE TAKEN	EXPLANATION
BALANCE BROUGHT FORWARD FROM LAST YEAR ----------																								
JAN.																								
FEB.																								
MAR.																								
APR.																								
MAY																								
JUNE																								
JULY																								
AUG.																								
SEPT.																								
OCT.																								
NOV.																								
DEC.																								

V - VACATION LEAVE S - SICK LEAVE L - LOST TIME OL - OTHER AUTHORIZED LEAVE

SHOW VACATION, SICK LEAVE AND OTHER ABSENCES IN DAYS AND HALF DAYS.

* EXCEPTIONS TO THE NORMAL WORK SCHEDULE SHALL BE NOTED AND ATTACHED TO THIS FORM.

EXHIBIT M

EMPLOYEE'S EARNINGS RECORD

UNIT _____
OFFICE, BOARD OR DEPARTMENT _____
(SEE OTHER SIDE FOR INSTRUCTIONS)

BASIS OF PAY (PER MONTH, WEEK, HOUR) _____
OTHER COMPENSATION TYPE
AMOUNT _____
EXEMPTION STATUS FEDERAL _____ STATE _____

MR., MRS., MISS _____
ADDRESS _____
CITY _____ ZIP CODE _____
SOC. SEC. NO. _____

FORM PRESCRIBED BY STATE BOARD OF ACCOUNTS

General Payroll Form 99B (Rev. 1985)

		DATE OF WARRANT	PAYROLL PERIOD ENDING	Code	NONCASH BENEFITS	GROSS PAY	TOTAL	DEDUCTIONS								AMOUNT OF WARRANT	WARRANT NUMBER
								FEDERAL WITH. TAX	SOCIAL SECURITY	STATE WITH. TAX	INSURANCE	RETIREMENT					
		FORWARD															
	1																
	2																
	3																
	4																
	5																
	6																
	7																
	8																
	9																
	10																
	11																
	12																
	13																
	14																
		TOTAL 1ST QUARTER															
	1																
	2																
	3																
	4																
	5																
	6																
	7																
	8																
	9																
	10																
	11																
	12																
	13																
	14																
		TOTAL 2ND QUARTER															
		TOTAL TO DATE															

EXHIBIT N

EXHIBIT O

Prescribed by State Board of Accounts Form No. 509 (1967)

________ Fund

No. ________

Appr. No. ______ $ ______
______ $ ______
______ $ ______
______ $ ______
______ $ ______

Pay to the Order of ________________ $ ______

________________ 100 Dollars

In Payment of Claim No. ________

____
Treasurer

Prescribed by State Board of Accounts Form No. 509 (1967)

________ Fund

No. ________

Appr. No. ______ $ ______
______ $ ______
______ $ ______
______ $ ______
______ $ ______

Pay to the Order of ________________ $ ______

________________ 100 Dollars

In Payment of Claim No. ________

____
Treasurer

Prescribed by State Board of Accounts Form No. 509 (1967)

________ Fund

No. ________

Appr. No. ______ $ ______
______ $ ______
______ $ ______
______ $ ______
______ $ ______

Pay to the Order of ________________ $ ______

________________ 100 Dollars

In Payment of Claim No. ________

____
Treasurer

Prescribed by State Board of Accounts Form No. 509 (1967)

________ Fund

No. ________

Appr. No. ______ $ ______
______ $ ______
______ $ ______
______ $ ______
______ $ ______

Pay to the Order of ________________ $ ______

________________ 100 Dollars

In Payment of Claim No. ________

____
Treasurer

Prescribed by State Board of Accounts Form No. 509 (1967)

________ Fund

No. ________

Appr. No. ______ $ ______
______ $ ______
______ $ ______
______ $ ______
______ $ ______

Pay to the Order of ________________ $ ______

________________ 100 Dollars

In Payment of Claim No. ________

____
Treasurer

Prescribed by State Board of Accounts

Form No. 516 (1967)

PAYROLL CHECK

No. P ______________

Fund ______________

PR Claim No. ______________

Pay to the Order of ______________ $ ______

______________ Dollars
100

Hours Worked	Gross Pay	Federal With. Tax	Social Security	State With. Tax	Retire-ment	Insur-ance		

____
Treasurer

Prescribed by State Board of Accounts

Form No. 516 (1967)

PAYROLL CHECK

No. P ______________

Fund ______________

PR Claim No. ______________

Pay to the Order of ______________ $ ______

______________ Dollars
100

Hours Worked	Gross Pay	Federal With. Tax	Social Security	State With. Tax	Retire-ment	Insur-ance		

____
Treasurer

Prescribed by State Board of Accounts

Form No. 516 (1967)

PAYROLL CHECK

No. P ______________

Fund ______________

PR Claim No. ______________

Pay to the Order of ______________ $ ______

______________ Dollars
100

Hours Worked	Gross Pay	Federal With. Tax	Social Security	State With. Tax	Retire-ment	Insur-ance		

____
Treasurer

Prescribed by State Board of Accounts

Form No. 516 (1967)

PAYROLL CHECK

No. P ______________

Fund ______________

PR Claim No. ______________

Pay to the Order of ______________ $ ______

______________ Dollars
100

Hours Worked	Gross Pay	Federal With. Tax	Social Security	State With. Tax	Retire-ment	Insur-ance		

____
Treasurer

Prescribed by State Board of Accounts

Form No. 516 (1967)

PAYROLL CHECK

No. P ______________

Fund ______________

PR Claim No. ______________

Pay to the Order of ______________ $ ______

______________ Dollars
100

Hours Worked	Gross Pay	Federal With. Tax	Social Security	State With. Tax	Retire-ment	Insur-ance		

____
Treasurer

EXHIBIT Q

Prescribed by State Board of Accounts

School City and Town Form No. 517 (Rev. 1997)

RECEIPT

OFFICE OF TREASURER OF SCHOOL BOARD

NO. _____

_____
(SCHOOL CORPORATION)

_____ IN _____ 20___

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

RECEIVED FROM _____ $_____

THE SUM OF _____ DOLLARS

100

ON ACCOUNT OF _____

_____

_____
TREASURER OF SCHOOL BOARD

Prescribed by State Board of Accounts

School City and Town Form No. 517 (Rev. 1997)

RECEIPT

OFFICE OF TREASURER OF SCHOOL BOARD

NO. _____

_____
(SCHOOL CORPORATION)

_____ IN _____ 20___

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

RECEIVED FROM _____ $_____

THE SUM OF _____ DOLLARS

100

ON ACCOUNT OF _____

_____

_____
TREASURER OF SCHOOL BOARD

Prescribed by State Board of Accounts

School City and Town Form No. 517 (Rev. 1997)

RECEIPT

OFFICE OF TREASURER OF SCHOOL BOARD

NO. _____

_____
(SCHOOL CORPORATION)

_____ IN _____ 20___

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

RECEIVED FROM _____ $_____

THE SUM OF _____ DOLLARS

100

ON ACCOUNT OF _____

_____

_____
TREASURER OF SCHOOL BOARD

Prescribed by State Board of Accounts

General Form No. 350
(Revised 1983)

REGISTER OF INVESTMENTS

Name of Unit ______________________________ ______________________________ Fund

(USE SEPARATE SHEET(S) FOR EACH INVESTMENT FUND. LIST EACH SECURITY INDIVIDUALLY.)

Date of Purchase	Nature of Investment	Serial No.	SAFEKEEPING RECEIPT		Maturity Date	Rate of Interest	Maturity Value	AMOUNT PAID			Date Sold or Redeemed	AMOUNT RECEIVED			INTEREST EARNED		INTEREST RECEIVED	
			Issued By	No.				Principal	Accrued Interest	Total Paid		Principal	Interest	Total Received	Date	Amount	Date	Amount

Interest Earned for Each Investment on Hand at December 31. - Calculated By: Multiply: Rate of Interest Principal X (Times) Number of Days from Date of Purchase to December 31 Divided By: 360 (Days) (Investments purchased and then either sold or redeemed in the same calendar year don't need a calculation because interest earned equals interest received.)

EXHIBIT R

Form Prescribed by State Board of Accounts

School Form No. TBR-2 (Rev. 1997)

OFFICIAL RECEIPTS - INDIVIDUAL TEXTBOOK RENTAL LIST

_____ SCHOOL, _____, INDIANA

Receipt 0001

Date _____ Name of Student _____ Grade _____

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

Quantity	Description - Name - Series - Code	Unit Price	Total Rental Fee	For Use of Issuing Officer
Total Received		$	$	

NOTE TO STUDENTS AND PARENTS:

Care should be exercised in the use of rented textbooks in order that all books may be returned at the close of the school term in useable condition. For each textbook lost or returned damaged beyond use, an additional charge may be made as determined by school officials. Items available for classroom use not issued to students shall also be listed. If the volume of transactions for grades with a fixed list of books and materials is great enough to demand it, a copy of the printed list may be attached to the TBR-2 form and the form processed with a reference to such attached list instead of further itemization.

_____ Issuing Officer

EXHIBITS

General Form No. 369 (Rev. 2019)

CAPITAL ASSETS LEDGER

FUND _____

DEPARTMENT OR BUILDING _____

	Date of Purchase	Description of Asset	Serial Number	Location of Asset	Original Cost of Asset	Estimated Life of Asset	Date of Disposal of Capital Asset	Amount Received on Disposal or Trade in	Types of Capital Assets							Total Capital Assets
									Land	Infrastructure	Buildings	Improvements Other Than Buildings	Machinery Equipment & Vehicles	Construction in Progress	Books and Other	
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
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26																
27																
28																
29																
30																

TRANSFER TUITION STATEMENT
School Year 2018-2019
Estimated Billing

To: _____ **Corp. No.** _____ **Corp. name** _____ **County**
Transferor Corporation

From: _____ **Corp. No.** _____ **Corp. name** _____ **County**
Transferee Corporation

Number Of Days School Was In Session For Pupil Attendance _____

	ADM	%		ADM	%
Kindergarten			**Special Program #1**		
Elementary			**Special Program #2**		
Middle/Jr. High			**Special Program #3**		
Senior High School			**Special Program #4**		
Total					

GENERAL FUND (JULY TO DECEMBER 2018) or EDUCATION AND OPERATIONS FUND COSTS **Class of School** _____
(JANUARY TO JUNE 2019) OPERATING COSTS ACCORDING TO CLASSIFIED BUDGET ACCOUNTS

1.	**INSTRUCTION - REGULAR AND SPECIAL PROGRAMS** Accounts 11000 and/or 12000, and 16100 and/or 16200 - General/Education Funds Only	$
2.	**SUPPORT SERVICES - ADMINISTRATION** Accounts 21800,23120, 23160, 23190,23200 and 24000 - General/Education/Operations Funds Only	
3.	**SUPPORT SERVICES - ATTENDANCE, HEALTH, AND GUIDANCE** Accounts 21100 through 21700 - General/Education Funds Only	
4.	**SUPPORT SERVICES - OPERATION AND MAINTENANCE** Accounts 26000 - General/Operations Funds Only	
5.	**SUPPORT SERVICES - CENTRAL** Accounts 25000 (Excluding 25191-25196 and 25910-25950) -General/Education/Operations Fund	
6.	**SUPPORT SERVICES - OTHER** Accounts 22000, 31000 - General/Education/Operations Funds Only	
7.	**INSTRUCTION - PAYMENTS TO OTHER GOVERNMENTAL UNITS WITHIN STATE Accounts 17000** (excluding 17800) above paid from General/Education/Operations Funds Only through other agencies for appropriate class of school	
8.	**TOTAL OPERATING COSTS Lines 1 through 7 - General/Education/Operations Fund Only**	$

TRANSPORTATION

NOTE: Transportation expenses can be included in the Transfer Tuition Statement ONLY in instances where the transferred students are furnished transportation by the school corporation to which they are transferred and there is a written transportation agreement between the transferor and transferee school corporations.

Costs of Transportation Fund - Accounts 27000 (except 27400) (Transportation/Operations Funds) $ _____

Total number of Pupils Transported _____

Cost per pupil transported. $ _____

AMOUNT DUE FOR TRANSPORTATION

Cost per pupil (above) divided by numbers of days school was in session equals cost per pupil day:

_____ / _____ = _____

Cost per pupil day multiplied by total days transported equals cost of transporting pupils named in this statement:

_____ X _____ = $ _____

Class of School _____

STATEMENT OF ENROLLMENT, TRANSPORTATION AND ATTENDANCE

Name of Pupil Transferred	Date of Birth	Grade	Date First Enrolled	Date Last Enrolled	Fall # Days Enrolled	Spring # Days Enrolled	Included in Fall ADM	Included in Spring ADM	Days Provided Transportation in Fall	Days Provided Transportation in Spring	Spec. Ed. Student Count by Category (See Below)	Voc. Ed. Additional Pupil Count
Totals	**xxx**	**xxx**	**xxxxx**	**xxxxx**			**xxxxx**				**xxxxxx**	

SPECIAL EDUCATION CATEGORIES

A. Severe Disabilities B. Mild and Moderate Disabilities C. Communication Disorders (duplicated count)

(NOTE: Types A and B are unduplicated counts)

Class of School _____

A. 1. Total pupil days enrolled divided by the number of days school was in session for Fall pupil attendance equals half time pupil equivalent.

_____ ÷ _____ = _____

2. Total pupil days enrolled divided by the number of days school was in session for Spring pupil attendance equals half time pupil equivalent.

_____ ÷ _____ = _____

3. _____ + _____ = _____
Line A1/A2 Line A2/2 Full time pupil equivalent

B. 1. Total Operating Costs (from Fall line 8, page 1) divided by Pupil Enrollment equals Per Capita Cost

_____ ÷ _____ = $_____

2. Total Operating Costs (from Spring line 8, page 1) divided by Pupil Enrollment equals Per Capita Cost

_____ ÷ _____ = $_____

Total Operating Costs (from line 8, page 1) divided by Pupil Enrollment equals Per Capita Cost

3. _____ ÷ _____ = $_____
Line B1 Line B2 Total Per Capita Cost

C. Per Capita Cost (Section B) multiplied by full time pupil equivalent (Section A) equals Gross Amount due for Operating.

_____ X _____ = $_____
Line B3 Line A3

D. LESS the following state or local distributions that are computed in any part using ADM or other pupil count in which the student(s) is included: (Refer to the instructions in the Accounting and Uniform Compliance Guidelines Manual for Indiana Public School Corporations)

	Fall and Spring	**Fall**		**Spring**		
1	Basic Tuition Support under I.C. 20-43-6-3	$_____	+	$_____	=	$_____
	Fall only					
2	Honors Diploma under I.C. 20-43-10-2	$_____				
3	Special Education Grant under I.C. 20-43-7	$_____				
4	Career and Technical Education under IC 20-43	$_____				
5	Revenue under I.C. 20-45-7 & 8	$_____				
6	Operations Fund Excise revenue I.C. 20-26-11-13 (b)	$_____				
				Sec. D Total 1-6		$_____

E. Net Amount Due for Operating (Section C Minus Section D). **$**_____

Net Amount Due for Transfer Tuition - Operating (E) $_____

Net Amount Due for Transfer Tuition - Special Equipment (G page 4) $_____

Net Amount Due for Transportation (from Bottom page 1) $_____

TOTAL net amount due for Transfer Tuition and Transportation **$**_____

Less Quarterly Payments:

	Date	Estimated Amount
First Quarter	_____	$_____
Second Quarter	_____	$_____
Third Quarter	_____	$_____
	Total Quarterly Payments	**$**_____
Balance Due		**$**_____

If amount is negative, should default to zero

Note: half of each Fall and Spring calculation should be used.

Note: Student must have been included in the Fall count in order for these figures to be a part of the calculation. Grant amount should represent a fiscal year.

Class of School _____

I, _____ Treasurer of _____
School Corporation, _____ County, Indiana, hereby certifies that the cost of this corporations special equipment is as follows:

A Description	**B** Original Cost	**C** Year Pur.	**D** Est. Life	**E** Annual Allocated Cost	**F** Number of Students	**G** Special Equip. Cost for Student Named on Pg 2
Total Special Equipment Costs						$0.00

I further certify that the within named students were lawfully transferred to the above named corporation; that the transfers were issued by the proper legal offers of:

_____ (transferring corporation) _____ County, Indiana; or in the instance of a cash transfer; authorized by _____, residing at _____ address, as the parent or other person responsible for such transfer tuition; or in the Instance of lawfully placed students under IC 20-26-11 that the transfers were issued by the proper legal officer of _____ County.

Also that the foregoing statements of transfers, attendance, cost of education, cost of transportation, amount due for tuition, amount due for transporation of children who by law were furnished transportation by this school corporation is true and correct, as I verily believe.

Date: _____, 20 _____ (Signed) _____
Treasurer

Prescribed by State Board of Accounts

General Form 370 (1997)

_____

Governmental Unit

RECEIPT REGISTER

Receipt Date	Receipt Number	Receipt Amount	Received From	Fund	Description	Payment Type and Amount					
						Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other
TOTAL											

EXHIBIT V

[Insert School Corporation Name]

2022-2023 Household Application for Curricular Material Assistance and Other Assistance

Complete one application per household. Please use a pen (not a pencil).

Prescribed by State Board of Accounts
School Form No. 521/2022

STEP 1 List ALL infants, children, and students up to grade 12 who are members of your household (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless**, **Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

	Child's First Name	MI	Child's Last Name	Student? Yes	Student? No	Only Students: Name of School Building	Only Students: Birthdate	Only Students: Grade	Living with parent or caretaker relative? Yes	Living with parent or caretaker relative? No	Check all that apply: Foster Child	Check all that apply: Homeless, Migrant, Runaway
1				☐	☐				☐	☐	☐	☐
2				☐	☐				☐	☐	☐	☐
3				☐	☐				☐	☐	☐	☐
4				☐	☐				☐	☐	☐	☐
5				☐	☐				☐	☐	☐	☐

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP (Food Stamp) or TANF?

If NO > Go to STEP 3.

If YES > Write a case number here then go to STEP 4 (Do not complete STEP 3)

Case Number: / / / / / / / / /

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what to do here?

Please read **How to Apply for Free and Reduced Price School Meals** for more information.

The **Sources of Income for Children** section will help you with the **Child Income** question.

The **Sources of Income for Adults** section will help you with the **All Adult Household Members** section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all children in household listed in STEP 1 here.

Child income $ ____ How often? ◯ Weekly ◯ Every 2 Wks ◯ 2x Month ◯ Monthly

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report **total (gross) income before any taxes or deductions** for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

	Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly / Every 2 Wks / 2x Month / Monthly	Public Assistance/ Child Support/Alimony	How often? Weekly / Every 2 Wks / 2x Month / Monthly	Pensions/Retirement/ All Other Income	How often? Weekly / Every 2 Wks / 2x Month / Monthly
1		$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯
2		$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯
3		$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯
4		$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯
5		$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯	$	◯ ◯ ◯ ◯

Total Household Members (Children and Adults) ____

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X ____ **Check if no SSN** ☐

STEP 4 Contact information and adult signature. Mail Completed Form To: [INSERT YOUR SCHOOL MAILING ADDRESS HERE]

Do you want to receive Curricular Material Assistance?

◯ Yes **If yes, sign to the right** →

◯ No

My signature below authorizes the release of information on this application for curricular material assistance. I give up my right of confidentiality for this purpose only. The application may be subject to audit by the State of Indiana to determine student eligibility for curricular materials. The application information may be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. Parts 260 and 265. I certify that I am the parent/guardian of the child(ren) for whom application is being made and authorize the release of information for the purposes outlined in the application.

Signature of adult completing the form ____ Today's date ____

Street Address (if available) ____ Apt # ____ City ____ State ____ Zip ____ Daytime Phone and Email (optional) ____

STEP 5 Other Assistance Opportunities (Optional)

This application information may be shared with the Family and Social Services Administration for the purpose of identifying children who may qualify for free or low-cost health insurance under **Medicaid** or **Hoosier Healthwise**. If you want the application information shared for this purpose, please sign below. I certify I am the parent/guardian of the child(ren) for whom application is being made. I authorize the release of information for this purpose only.

Signature of adult completing the form

Today's date

For information about Hoosier Healthwise health insurance, call 1-800-889-9949.

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for curricular material and other benefits.

Ethnicity (check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (check one or more):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Use of Information Statement: This explains how we will use the information you give us. The information contained in the application will be used to determine eligibility for curricular materials assistance under Indiana Code 20-33. You do not have to provide the information, but if you do not, we cannot approve your child for curricular materials assistance. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) case number for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for the State of Indiana school curricular materials program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

INCOME CONVERSION to YEARLY:			
WEEKLY X 52	EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size:_____ Total Income:$_____ per: ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
OR Categorical Eligibility: ☐ Food Stamps/TANF ☐ Migrant ☐ Homeless ☐ Runaway ☐ Foster
Eligibility Determination: ☐ Approved Free ☐ Approved Reduced Price ☐ Denied
Reason for Denial: ☐ Income Too High ☐ Incomplete Application ☐ Other_____
Type of Eligibility Notification Provided (if denied, notification must be written): ☐ Verbal ☐ Written Date:_____
Signature of Determining Official: _____ Date:_____ Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____ Application Direct Verified? Yes ☐ No ☐

Date Verification Notice Sent:_____ Date Response Due from Households:_____ Date Second Notice Sent (or N/A): _____	Approval Based On: ☐ Food Stamps / TANF Case Number ☐ Household Size and Income ☐ Other _____	Verification Results: ☐ No Change ☐ Free to Reduced ☐ Free to Paid ☐ Reduced to Free ☐ Reduced to Paid	Reason for Change: ☐ Income:_____ ☐ Household Size: _____ ☐ Change in Food Stamps /TANF ☐ Did not respond ☐ Other: _____	Date Notice of Change Sent:_____ Date Change Made:_____
Request for Appeal Date Hearing Requested:_____ Hearing Decision: _____	Verifying Official's Signature:_____ Date:_____			

[Insert School Corporation Name]

2022-2023 Household Application for Free and Reduced Price School Meals

Complete one application per household. Please use a pen (not a pencil).

Prescribed by State Board of Accounts
School Form No. 521/2022

STEP 1 List ALL infants, children, and students up to grade 12 who are members of your household (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless**, **Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

	Child's First Name	MI	Child's Last Name	Student? Yes	Student? No	Only Students: Name of School Building	Only Students: Birthdate	Only Students: Grade	Living with parent or caretaker relative? Yes	Living with parent or caretaker relative? No	Check all that apply: Foster Child	Check all that apply: Homeless, Migrant, Runaway
1				☐	☐				☐	☐	☐	☐
2				☐	☐				☐	☐	☐	☐
3				☐	☐				☐	☐	☐	☐
4				☐	☐				☐	☐	☐	☐
5				☐	☐				☐	☐	☐	☐

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP (Food Stamp) or TANF?

If NO > Go to STEP 3.

If YES > Write a case number here then go to STEP 4 (Do not complete STEP 3)

Case Number: / / / / / / / / /

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what to do here?

Please read **How to Apply for Free and Reduced Price School Meals** for more information.

The **Sources of Income for Children** section will help you with the **Child Income** question.

The **Sources of Income for Adults** section will help you with the **All Adult Household Members** section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all children in household listed in STEP 1 here.

Child income	How often? Weekly	Every 2 Wks	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report **total (gross) income before any taxes or deductions** for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

	Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Every 2 Wks	2x Month	Monthly	Public Assistance/ Child Support/Alimony	How often? Weekly	Every 2 Wks	2x Month	Monthly	Pensions/Retirement/ All Other Income	How often? Weekly	Every 2 Wks	2x Month	Monthly
1		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
2		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
3		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
4		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
5		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults) ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X ☐☐☐☐ **Check if no SSN** ☐

STEP 4 Contact information and adult signature. Mail Completed Form To: [INSERT YOUR SCHOOL MAILING ADDRESS HERE] Turn for Textbook Benefits

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Printed name of adult completing the form

Signature of adult completing the form

Today's date

Street Address (if available)

Apt #

City

State

Zip

Daytime Phone and Email (optional)

STEP 5 Other Benefits – This section does not need to be completed to receive free or reduced price meal benefits.

Do you want to receive **Textbook Assistance**?

◯ Yes

◯ No

If yes, **sign to the right** →

I certify that I am the parent/guardian of the child(ren) for whom application is being made. My signature below authorizes the release of information on this application for textbook assistance. I give up my right of confidentiality for this purpose only. This application information will be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. Parts 260 and 265.

Signature of adult completing the form _____ Today's date _____

School Use Only:
- ☐ Approved
- ☐ Denied
- ☐ Not Applicable

This application information may be shared with the Family and Social Services Administration for the purpose of identifying children who may qualify for free or low-cost health insurance under **Medicaid** or **Hoosier Healthwise**. If you want the application information shared for this purpose, please sign below. I certify I am the parent/guardian of the child(ren) for whom application is being made. I authorize the release of information for this purpose.

For information about Hoosier Healthwise health insurance, call 1-800-889-9949.

Signature of adult completing the form _____ Today's date _____

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (check one or more):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: **mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:**program.intake@usda.gov

This institution is an equal opportunity provider.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

INCOME CONVERSION to YEARLY:

WEEKLY X 52	EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size:_____ Total Income:$_____ per: ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

OR Categorical Eligibility: ☐ Food Stamps/TANF ☐ Migrant ☐ Homeless ☐ Runaway ☐ Foster

Eligibility Determination: ☐ Approved Free ☐ Approved Reduced Price ☐ Denied

Reason for Denial: ☐ Income Too High ☐ Incomplete Application ☐ Other_____

Type of Eligibility Notification Provided (if denied, notification must be written): ☐ Verbal ☐ Written Date:_____

Signature of Determining Official: _____ Date:_____ Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____ Application Direct Verified? Yes ☐ No ☐

Date Verification Notice Sent:_____ Date Response Due from Households:_____ Date Second Notice Sent (or N/A): _____	Approval Based On: ☐ Food Stamps / TANF Case Number ☐ Household Size and Income ☐ Other _____	Verification Results: ☐ No Change ☐ Free to Reduced ☐ Free to Paid ☐ Reduced to Free ☐ Reduced to Paid	Reason for Change: ☐ Income:_____ ☐ Household Size: _____ ☐ Change in Food Stamps /TANF ☐ Did not respond ☐ Other: _____	Date Notice of Change Sent:_____ Date Change Made:_____

Request for Appeal
Date Hearing Requested:_____
Hearing Decision: _____

Verifying Official's Signature:_____ Date:_____

SAMPLE
SUGGESTED FORMAT

SPECIAL PURCHASE CONTRACT FILE LIST

Contract No.	Date of Contract	Contractor Name	Contract Amount	Type of Contract	Description of Supplies	IC Reference Basis for Special Purchase	Basis of Selection of Contractor

Source: IC 5-22-10-3

Prescribed by State Board of Accounts 1964 GENERAL FORM NO. 351

REGISTER OF INSURANCE

UNIT AND DEPT. OR OFFICE ______________________________ CLASSIFICATION ______________________

	INSURANCE COMPANY	POLICY NO.	RENEWAL OR REPLACEMENT OF POLICY NO.	AMOUNT OF POLICY	TYPE OF COVERAGE	PROPERTY COVERED	EFFECTIVE DATE	TERM	EXPIRATION DATE	FUND(S) FROM WHICH PAID	PREMIUMS					
												1ST YEAR	2ND YEAR	3RD YEAR	4TH YEAR	5TH YEAR
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REMARKS