

- Initial Budget       Amendment (No. \_\_\_\_\_)  
 Revised Initial Budget       Multi-district Application

**ILLINOIS STATE BOARD OF EDUCATION**  
 Special Education Services  
 100 North First Street. N-253  
 Springfield, Illinois 62777-0001

**FY 2010**

**SCHOOL MENTAL HEALTH SUPPORT GRANTS**

**Budget Summary and Payment Schedule**  
*Use whole dollars only. OMIT DOLLAR SIGNS, COMMAS, AND DECIMAL PLACES, e.g., 2536*

<b>ISBE USE ONLY</b>	PROGRAM APPROVAL DATE AND INITIALS	
	TOTAL FUNDS	
	CARRYOVER FUNDS	
	CURRENT FUNDS	
	BEGIN DATE	END DATE

FISCAL YEAR <b>10</b>	SOURCE OF FUNDS CODE <b>3990-SO</b>	REGION, COUNTY, DISTRICT, TYPE CODE	SUBMISSION DATE
APPLICANT NAME/FISCAL AGENT			
PROJECT CONTACT PERSON		TELEPHONE NUMBER (Include Area Code)	
E-MAIL ADDRESS		FAX NUMBER (Include Area Code)	

LINE	FUNCTION NUMBER (1)	EXPENDITURE ACCOUNT (2)	SALARIES (3)	EMPLOYEE BENEFITS (4)	PURCHASED SERVICES (5)	SUPPLIES AND MATERIALS (6)	CAPITAL OUTLAY** (7)	OTHER OBJECTS (8)	NON-CAPITALIZED EQUIPMENT** (9)	TOTAL (11)	PAYMENT SCHEDULE
			(Obj. 100s)	(Obj. 200s)	(Obj. 300s)	(Obj. 400s)	(Obj. 500s)	(Obj. 600s)	(Obj. 700s)		
1	1000	Instruction									July-August
2	2110	Attendance & Social Work Services									September
3	2120	Guidance Services									October
7	2210	Improvement of Instruction Services									November
10	2300	General Administration									December
13	2520	Fiscal Services*									January
16	2550	Pupil Transportation Services									February
17	2560	Food Services									March
20	2620	Planning, Research, Dev. & Eval. Services									April
24	2900	Other Support Services									May
25	3000	Community Services									June
26	4000	Payments to Other Districts or Gov't. Units									July-August
28	Total Direct Costs										<b>TOTAL</b>
29	Approved Indirect Costs x _____%										
30	TOTAL BUDGET										

\* If expenditures are shown, the indirect costs rate cannot be used.

\*\* Not applicable to all grants, and in no instances can Capital Outlay and Non-Capitalized Equipment or Facilities Acquisition & Construction Services be included in the indirect costs application.

\_\_\_\_\_ Date      \_\_\_\_\_ Original Signature of Superintendent or Administrator      \_\_\_\_\_ Date      \_\_\_\_\_ Original Signature of ISBE Division Administrator

APPLICANT NAME/FISCAL AGENT
REGION, COUNTY, DISTRICT, TYPE CODE

**'FY 2010**  
**'G7 <CC@A9BH5 @<95 @H'GI DDCFH'; F5 BHG'**  
**5 A9B8A9BH'6I 8; 9H'GI AA5FM6F95?8CKB'**

Provide an itemized breakdown of the line item expenditure accounts listed on the Budget Summary. Identify on the right side only expenditure accounts to be amended. Amounts shown on this budget amendment will supersede all previously approved budgets. (Duplicate additional pages as necessary.)

Function Number (1)	Object Number (2)	Itemization (3)	Currently Approved Amount (4)	Requested Change (+ Or -) (5)	Revised Amount (6)	Rationale For Requested Change (7)
<b>NET CHANGE (+ or -)</b>						

APPLICANT NAME/FISCAL AGENT
REGION, COUNTY, DISTRICT, TYPE CODE

**FY 2010**  
**'G7 < CC @A9BH5 @<95 @H< 'GI DDCFH'; F5 BHG**  
**AMENDMENT BUDGET SUMMARY BREAKDOWN**

Provide an itemized breakdown of the line item expenditure accounts listed on the Budget Summary. Identify on this side only expenditure accounts to be amended. Amounts shown on this budget amendment will supersede all previously approved budgets. (Duplicate additional pages as necessary.)

Function Number (1)	Object Number (2)	Itemization (3)	Currently Approved Amount (4)	Requested Change (+ Or -) (5)	Revised Amount (6)	Rationale For Requested Change (7)
<b>NET CHANGE (+ or -)</b>						