

Initial Budget Revised Initial Budget
 Amendment # _____

PROJECT NUMBER			
FISCAL YEAR 09	SOURCE OF FUNDS CODE 3990-SO	REGION, COUNTY, DISTRICT, TYPE CODE	LEA SUBMISSION DATE
JOINT AGREEMENT/DISTRICT/AGENCY NAME			
CONTACT NAME		TELEPHONE (Include Area Code)	
E-MAIL		FAX (Include Area Code)	

ILLINOIS STATE BOARD OF EDUCATION

Special Education Services Division
 100 North First Street, N-253
 Springfield, IL 62777-0001

**FY 2009
 SCHOOL MENTAL HEALTH SUPPORT GRANTS**

Budget Summary and Payment Schedule
 Use whole dollars only. Omit Commas and Decimal Places, e.g., \$2536

ISBE USE ONLY	ISBE PROGRAM APPROVAL DATE	
	TOTAL FUNDS	
	CARRYOVER FUNDS	
	CURRENT FUNDS	
	BEGIN DATE	END DATE

LINE	FUNCTION NUMBER 1	EXPENDITURE ACCOUNT 2	SALARIES 3	EMPLOYEE BENEFITS 4	PURCHASED SERVICES 5	SUPPLIES & MATERIALS 6	CAPITAL OUTLAY** 7	TOTAL 11	PAYMENT SCHEDULE
			(Obj. 100s)	(Obj. 200s)	(Obj. 300s)	(Obj. 400s)	(Obj. 500s)		
2	2110	Attendance and Social Work Services							May
3	2120	Guidance Services							June
7	2210	Improvement of Instructional Services							July
10	2300	General Administration*							August
16	2550	Pupil Transportation Services							September
17	2560	Food Services							October
20	2620	Planning, Research, Dev. And Eval. Servs.							November
24	2900	Other Support Services							December
25	3000	Community Services							January
26	4000	Payment to Other Districts And Govt. Units							February
28	Total Direct Costs								March
30	TOTAL BUDGET								April
									TOTAL
									\$ _____

*Must not exceed 5% of total budget requested.

**Not applicable to all grants, and in no instances can Capital outlay or Facilities Acquisition & Construction Services be included in the indirect costs application.

 Date Signature of Superintendent or Administrator

 Date Original Signature of Division Administrator,
 Special Education Services

