

REIMBURSEMENT REQUEST FORM

Fiscal Year _____
 Claim Period: 7/1-9/30 10/1-12/31 1/1-3/31 4/1-6/30
 (circle one)
 Report Due: no later than 8/15 of following fiscal year

County Office: _____
 Contact Name: _____
 Address: _____
 District: _____

Costs were incurred as a result of (check each category that applies):

- 1. Audit – Extraordinary Costs – EC 1241.5(b) & (c), BA Provision 7 _____
- 2. Disapproved Budget by COE – EC 42127 (d) _____
- 3. Disapproved Budget by SPI (following BRC or waiver) – EC 42127.3 (b)(4) _____
- 4. Disapproved Budget by SPI (following BRC or waiver) – EC 42127.3 (b)(6) _____
- 5. Qualified Certification – EC 42127.6 (a)(1)(A) _____
- 6. Qualified Certification – EC 42127.6 (a)(1)(B) _____
- 7. Negative Certification – EC 42127.6 (e)(5) _____

Please explain the circumstances (on a separate sheet of paper) leading to the county's involvement and the actual activities performed by the county, in sufficient detail to determine if reimbursement is appropriate. Attach any relevant correspondence between the county and the district.

A Object	B Description	C Total Cost of COE Oversight	D 25% Reimbursement amount for Disapproved Budget, Qualified Certification, Negative Certification	E 100% Reimbursement For AB 139 Extraordinary Costs of Audit
1300	Certificated Supervisors' and Administrators Salaries			
1900	Other Certificated Salaries			
2300	Classified Supervisors' and Administrators Salaries			
2400	Clerical, Technical and Office Staff Salaries			
2900	Other Classified Salaries			
3000	Employee Benefits			
4300	Other Supplies			
5200	Travel and Conferences			
5800	Prof'l/Consultg Svcs/Op Exp			
	Other Expenditures			
TOTAL	Attach detail for each expenditure, i.e., employee salaries/benefits or payments for consultant services, including number of hours and rate of pay.			

Certification: I certify that the expenditures reported have been made in accordance with applicable state laws and regulations; full documentation of all expenditure detail and payment is included with this claim; and, copies of AB 139 audit reports are included, if applicable.

Signature _____
 Typed Name _____
 Title _____
 Date _____

Submit two sets of documents with original signature on each claim form to:
 Fiscal Crisis and Management Assistance Team
 Office of Larry E. Reider – Administering Agent
 Kern County Superintendent of Schools
 1300 17th Street – CITY CENTRE
 Bakersfield, CA 93301-4533