CLAIM FOR REIMBURSEMENT ____________________________ EXPENDITURES - APPROVED DISTRICT PLANS - TITLE ____

State Form 45529 (R2 / 2-06) / FM 0411
Approved by State Board of Accounts, 2006

District	County	Date (*month, day, year*)

1	2	3	4	5	6		7	8	9	10
CASE NUMBER	CHILD'S NAME	PAYEE	ACCT #	SUB-ACCOUNT NUMBER	DATES OF SERVICE		COUNTY CLAIM NUMBER	DATE OF COUNTY WARRANT	COUNTY WARRANT NUMBER	AMOUNT OF COUNTY WARRANT ELIGIBLE FOR REIMBURSEMENT
					FROM	TO				
									TOTAL	$

DISTRIBUTION: Send white and canary copies of FM 0411 and white and canary copies of FM 0412 and FM 0413 to:

Family and Social Services Administration
Department of Child Services
402 West Washington Street, Room W364
ATTN: Account Clerk
Indianapolis, IN 46204

Retain the pink copy in County file.