CLAIM - VOUCHER

State Form 49792 (R2 / 12-05) / CW 3313
Approved by State Board of Accounts, 2000

Name of agency personnel who prepared this claim.	
Telephone number ( )	Date (*month, day, year*)

INSTRUCTIONS: This agency is requesting disclosure of your Social Security number in accordance with I.C. 4-1-8.

VENDOR INFORMATION		AGENCY INFORMATION	
Document number **C 500**	Address (*month, day, year*)	Name of agency **DCS**	
Name of vendor		Agency number **502**	
Address (*number and street*)		Social Security number	1099 CODE
Address (*P.O. Box number*)		Federal I.D. number	1099 CODE
City, State, ZIP code (*00000-0000*)		Vendor number	

AREA BELOW TO BE COMPLETED BY AGENCY

DATE		AMOUNT	FUND	OBJECT	CENTER	LOAN/INV/NBR	QTY.	UNIT	DESCRIPTION
									NC
									Title of program
									Contract number
									Account number
									Line number
									Funding years
									County(ies)

GROSS AMOUNT	Furnished to: (*name of state agency*) **Department of Child Services** **Financial Management**

I certify that this claim is correct and valid and is a proper charge against the state agency, fund , and center indicated.

Authorized signature of state agency	Date (*month, day, year*)

Pursuant to the provisions and penalties of Indiana Code 5-11-10-1, 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.

Signature of vendor	Date (*month, day, year*)