



| Requesting District | | |
|----------------------------|-----------|----------------------|
| 1. District Name: | | County: |
| Address: | | |
| City: | State: CO | Zip: |
| 2. Contact Name: | | Contact Phone: Fax: |
| Contact E-mail: | | Date of Request: |
| 3. Project Title: | | |
| Awarded BEST FY: | | CDE Accounting PO #: |

| Breakdown of Dollars Requested | | |
|---------------------------------------|--------------|----------------------|
| | Vendor Name: | Total of Invoice(s): |
| Vendor 1 | | |
| Vendor 2 | | |
| Vendor 3 | | |
| Vendor 4 | | |
| Vendor 5 | | |
| Vendor 6 | | |
| Vendor 7 | | |
| Vendor 8 | | |

| | | |
|--|----------------------------|--|
| Note: Fund requests can be submitted once a month. Please provide invoices from all vendors listed above. Statements and purchase orders will not be accepted. | Total Vendor Costs: | |
|--|----------------------------|--|

******Please fill out the three boxes below prior to submittal******

| | | |
|--|--|----------------------------------|
| <u>Grantee Adjusted Match %</u> | <u>Total Prior Billings (previous line 8 total)</u> | <u>Total Project Cost</u> |
|--|--|----------------------------------|

| Financial Summary of Project | | | |
|---|-------------|---------------|-------|
| | State Grant | Grantee Match | Total |
| 4. Total Amount of the Contribution/Grant | | | |
| 5. Amount Previously Paid/Requested to Date | | | |
| 6. Amount Available before Current Request | | | |
| 7. Amount of this Request | | | |
| 8. Total Billings to Date | | | |
| 9. Total Available Balance | | | |

| | | |
|----------------------------|-------------|------------------|
| 10. Proposed Project Dates | Start Date: | Completion Date: |
|----------------------------|-------------|------------------|

The Grantee certifies that the above information is true; that the funds requested are for the project for which the grantee received the grant; and that the vendors listed provided services or materials for the project for which the grantee received the grant.

| | |
|--|--------|
| Printed Name of Authorized Representative: | Title: |
|--|--------|

| | |
|---|-------|
| Signature of Authorized Representative: | Date: |
|---|-------|

Return Funding Requests to: BESTSchools@cde.state.co.us
and Carbon Copy (CC): Your Regional Program Manager
FY24-25 and newer grants, submit to GAINS once approved by RPM