



STATE OF ARKANSAS
SCHEDULE OF CHECK-OFF CONTRIBUTIONS
CORPORATION INCOME TAX RETURN
ATTACH IMMEDIATELY AFTER SCHEDULE A OF ARKANSAS FORM AR1100CT

Name \_\_\_\_\_ FEIN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

INSTRUCTIONS: Check the appropriate box and then enter the designated amount for each check-off in the box provided. Total your contributions and enter the amount in Box I. CONTRIBUTIONS ARE LIMITED TO WHOLE DOLLAR AMOUNTS ONLY.

FOR TAXPAYERS THAT ARE DUE A REFUND: This schedule must be attached to any return claiming a check-off contribution. Enter the amount from Box I (Total Check Off Contribution) from this schedule on Line 40 of the AR1100CT. The total amount you contribute will reduce your refund by a corresponding amount. If this schedule is not attached to your AR1100CT or if the amount in Box I is not entered on Line 40 of the AR1100CT, then your contribution will not be recognized and the amount will be refunded to you.

FOR TAXPAYERS THAT OWE ADDITIONAL TAXES: Detach this schedule and submit a separate check for the amount of your check-off contributions. Mail to: Arkansas Corporation Income Tax - P O Box 919, Little Rock, AR 72203-0919

A. ARKANSAS DISASTER RELIEF PROGRAM..... • \$ [ ]
[ ] \$1 [ ] \$5 [ ] \$10 [ ] \$20 [ ] \_\_\_\_\_ [ ] Your Total Refund
Write in Amount
B. ARKANSAS GAME AND FISH FOUNDATION..... • \$ [ ]
[ ] \$1 [ ] \$5 [ ] \$10 [ ] \_\_\_\_\_ [ ] Your Total Refund
Write in Amount
C. ARKANSAS SCHOOL FOR THE BLIND/SCHOOL FOR THE DEAF..... • \$ [ ]
[ ] \$1 [ ] \$5 [ ] \$10 [ ] \_\_\_\_\_ [ ] Your Total Refund
Write in Amount
D. BABY SHARON'S CHILDREN'S CATASTROPHIC ILLNESS PROGRAM..... • \$ [ ]
[ ] \$1 [ ] \$5 [ ] \$10 [ ] \$20 [ ] \_\_\_\_\_ [ ] Your Total Refund
Write in Amount
E. ORGAN DONOR AWARENESS EDUCATION PROGRAM..... • \$ [ ]
[ ] \$1 [ ] \$5 [ ] \$10 [ ] \_\_\_\_\_ [ ] Your Total Refund
Write in Amount
F. MILITARY FAMILY RELIEF PROGRAM..... • \$ [ ]
[ ] \$1 [ ] \$5 [ ] \$10 [ ] \$20 [ ] \_\_\_\_\_ [ ] Your Total Refund
Write in Amount
G. AREA AGENCIES ON AGING PROGRAM..... • \$ [ ]
[ ] \$1 [ ] \$5 [ ] \$10 [ ] \_\_\_\_\_ [ ] Your Total Refund
Write in Amount
H. NEWBORN UMBILICAL CORD BLOOD INITIATIVE..... • \$ [ ]
[ ] \$1 [ ] \$5 [ ] \$10 [ ] \$20 [ ] \_\_\_\_\_ [ ] Your Total Refund
Write in Amount
I. TOTAL CHECK OFF CONTRIBUTION..... • \$ [ ]