



STATE USE LAW COMMITTEE
ANNUAL CERTIFICATION

Name of Organization (D/B/A)

Address

City

State

Telephone

Fax

E-mail

Direct Labor Hours Report: (Report period 7/1-6/31)

- A. Workers with disabilities direct labor hours in all work services
B. Workers without disabilities direct labor hours in all work services
C. Total direct labor hours (A + B)

I certify that:

- Direct labor hours reported (Line A above) were performed by individuals with disabilities as defined by State Use Committee's Policies and Procedures.
There is a file on each individual with disabilities, which includes a written report prepared by a licensed physician, psychiatrist, and/or qualified psychologist reflecting the nature and extent of the disability or disabilities that cause such person to qualify as being a person with a disability, or is self-identified and will produce documentation on request.
If enrolled in services, there is a file on each individual with a disability which includes a report of service program evaluation and annual re-evaluation of the individual's capability for competitive employment prepared by a person or persons qualified by training and experience to evaluate work potential.
That in producing products or in the performance of service contracts through the act, the organization shall maintain a ratio of at least 51% people with disabilities working on State Use contracts.
Complies with Indiana laws governing private not-for-profit corporations.
The organization is certified by the Wage & Hour Division, U.S. Dept. of Labor (WH-228).
Meets standards for rehabilitation facilities mandated by the Indiana Family and Social Services Administration.
Affirmative Action procedures will be utilized in employment practices.

I understand that:

- I (my organization) is responsible for paying the Certified Coordinating Agency a 5% service Program Fee.

Signature of President/CEO

Name, Title and Date

For consideration to become a Certified Ability Indiana Organization, mail a copy of the completed Annual Certification form along with the Capability Inventory form to the following:

Ability Indiana  
c/o Asher Weaver  
615 N. Alabama St., Ste. 410  
Indianapolis, IN 46204

*For Internal Use Only*

RECOMMENDED BY CENTRAL COORDINATING AGENCY (CCA)

\_\_\_\_\_  
**Signature of CCA Representative**

\_\_\_\_\_  
**Typed Name, Title and Date**

RECOMMENDED BY STATE USE LAW COMMITTEE

\_\_\_\_\_  
**Signature of Committee Member**

\_\_\_\_\_  
**Typed Name, Title and Date**

\_\_\_\_\_  
**Minute #**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Posted by**

*(Revised 12.16.2019)*