Renewal Application For Prevention Counseling and Partner Elicitation (PCPE) Training Services

www.tdh.state.tx.us/hivstd
RFP HIV/TRNG 0105.2
Issue Date: ***07/18/2005***
Due Date: ***09/01/2005***

HIV/STD Comprehensive Services Branch
1100 W. 49th Street
Austin, Texas 78756-3199

Eduardo J. Sanchez, M.D., M.P.H.
Commissioner

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INFORMATION

I. INTRODUCTION

The Texas Department of State Health Services (DSHS) announces the expected availability of calendar year 2006 funding for the provision of Risk Reduction Specialist (RRS) and quality assurance training and technical assistance. This includes but is not limited to the DSHS Prevention Counseling and Partner Elicitation (PCPE) and related protocol based counseling courses. Current DSHS contractor(s) receiving funds under RFP HIV/TRNG 0105.1, Prevention Counseling and Partner Elicitation (PCPE) Training Services Request for Proposals, issued 08/23/04 are requested to submit a renewal application for the 2nd budget period within the 4-year project period. Renewal contracts will begin on or about 01/01/06 and will be for a 12-month budget period.

Any contract renewal is contingent upon the continued availability of funds and the satisfactory performance of the contractor during the prior budget period. Funding may vary and is subject to change each budget period. DSHS reserves the right to alter, amend or withdraw this Renewal Application at any time prior to the execution of a contract if funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or agencies, amendment of the appropriations act, health and human services agency consolidations, or any other disruption of current appropriations. If a contract has been fully executed and these circumstances arise, the provisions of the Termination Article in the contract General Provisions shall apply.

II. RENEWAL APPLICATION DEADLINE AND SUBMISSION

A. Application Deadline

The renewal application shall be received on or before the following date and time: ***2:00 P.M. C.S.T. on 09/01/05.***

B. Contact

For purposes of addressing questions concerning this Renewal Application, the contact is ***Debbie Bennett.*** All communications concerning this Renewal Application shall include the RFP #, be addressed in writing, and sent by fax or email to:

Debbie Bennett
Client Services Contracting Unit
Room T-502
Department of State Health Services

1100 West 49th Street
Austin, Texas 78756-3199
FAX (512) 458-7351
Email : ***debbie.bennettt@dshs.state.tx.us***
RFP # : ***HIV/TRNG 0105.2***

Upon issuance of this Renewal Application, other employees and representatives of DSHS will not answer questions or otherwise discuss the contents of the Renewal Application with any potential applicants or their representatives. Failure to observe this restriction may result in disqualification of any subsequent proposal. This restriction does not preclude discussions between affected parties for the purpose of conducting business unrelated to this Renewal Application.

Written inquiries or questions about this RFP shall be received no later than ***5:00 P.M. C.S.T. on 08/01/05***.

The Client Services Contracting Unit (CSCU) is the point of contact with regard to all procurement and contractual matters relating to the services described herein. CSCU is the only office authorized to clarify, modify, amend, alter, or withdraw the project requirements, terms, and conditions of this Renewal Application and any contract awarded as a result of this Renewal Application.

C. Assembly and Submission

1. Assembly

To facilitate review and processing, each renewal application should meet the following stylistic requirements:

- All pages clearly and consecutively numbered;
- Original and 2 copies unbound, but secured with binder clips or rubber bands;
- Typed (computer or typewriter);
- Single-spaced;
- 12-point font on 8 ½" x 11" paper with 1" margins;
- Blank forms provided in **SECTION IV. BLANK FORMS AND INSTRUCTIONS** shall be used (electronic reproduction of the forms is acceptable; however, all forms shall be identical to the original form(s) provided); and
- Signed in ink by an authorized official (copies must be signed but need not bear an original signature).

2. Submission

The originally signed renewal application and 2 copies shall be submitted **on or before the deadline to**:

Debbie Bennett
Client Services Contracting Unit
Room T- 502
Department of State Health Services
1100 West 49th Street
Austin, Texas 78756-3199

REF: RFP HIV/TRNG 0105.2

Renewal applications may be mailed or hand-delivered to the DSHS address above. If a renewal application is sent by overnight mail or hand-delivered to the DSHS address above, the applicant should request a receipt at the time of delivery to verify that the application was received on or before the due date and time. Hand-delivered applications must be delivered to the room number identified in the address above.

If a renewal application is mailed, it is considered as meeting the deadline if it is received on or before the due date and time. DSHS will not accept renewal applications by facsimile or e-mail.

Applicants sending renewal applications by the United States Postal Service or commercial delivery services must ensure that the carrier will be able to guarantee delivery of the renewal application by the closing date and time. DSHS may make exceptions only for 1) carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time; or 2) significant weather delays or natural disasters. The applicant must submit to DSHS proper documentation that reflects one of the above exceptions before DSHS can consider the application as having been received by the deadline.

III. RENEWAL APPLICATION ORGANIZATION AND CONTENT

The renewal application should be organized in the following order:

A. Face Page - Renewal Application as authorized under ***Prevention Counseling and Partner Elicitation (PCPE) Training Services Request for Proposal*** issued ***08/23/04,*** RFP HIV/TRNG 0105.1

B. Renewal Application Checklist

C. Contact Person Information

D. Administrative Information

E. Performance Measures

F. Work Plan

G. Budget

H. Nonprofit Board of Directors and Executive Director Assurances Form

IV. BLANK FORMS AND INSTRUCTIONS

Tip: To use the check box, place the pointer over the box and double click the left mouse button. In the Check Box Form Field Options, change the Default Value to Checked by clicking the circle in front of it.

Unlocked Forms

To have the computer do the addition:

1. Completely fill out the column or row you are going to sum. If you are summing all of the totals, update the sum of all the columns and all the rows before updating the sum of the totals.
2. Word will **not** update the totals automatically. Select the form field for the sum in one of the following ways:
   - Use the tab key to move from field to field or place the cursor immediately in front of the “0” or previous total with gray shading.

- Drag the cursor over the “0” or previous total with gray shading so that only the number is selected. Note: If the entire table cell is selected (black), the formula will not work and you risk deleting the form field.

Tip: The first time you use the forms, the totals are all “0” with gray shading. Before updating a total, Zoom in until you can easily see the “0” and the gray shading.

3. Press the F9 key (usually at the top of the keyboard).
4. Check the results. If it looks wrong, check the numbers you put in the row or column.

Caution: Never delete the form field for the total (the “0,” or previous total, with gray shading). The formulas will not work after the form field for the total is deleted. Selecting the field and typing over it will delete the field. The Backspace key will delete the field. The Delete key will delete the field.

Tip: You must update the totals for the columns and rows each time you change a number in that column or row.

Department of State Health Services (DSHS)

FORM A: FACE PAGE – Renewal Application as authorized under Prevention Counseling and Partner Elicitation (PCPE)Training Services Request for Proposals

This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the renewal application and shall be completed in its entirety.

APPLICANT INFORMATION

1) **LEGAL NAME:**

2) **MAILING Address Information** (include mailing address, street, city, county, state and zip code): **Check if address change** ☐

3) **PAYEE Mailing Address** (if different from above): **Check if address change** ☐

4) **Federal Tax ID No.** (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or **Social Security Number** (9 digit) : ***The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.***

5) **TYPE OF ENTITY** (check all that apply):

- ☐ City
- ☐ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): ____________

**If incorporated, provide 10-digit charter number assigned by Secretary of State:*

6) **Currently operating under a HUB Subcontracting plan on file at DSHS?** Yes ☐ No ☐

7) **PROPOSED BUDGET PERIOD:** Start Date: End Date:

8) **COUNTIES SERVED BY PROJECT:**

9) **AMOUNT OF FUNDING REQUESTED:**

10) **PROJECTED EXPENDITURES**

Does applicant's projected state or federal expenditures exceed $500,000 for applicant's current fiscal year (excluding amount requested in line 8 above)? **

Yes ☐ No ☐

***Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.*

11) **PROJECT CONTACT PERSON**

Name:
Phone:
Fax:
E-mail:

12) **FINANCIAL OFFICER**

Name:
Phone:
Fax:
E-mail:

I, the undersigned, am the authorized representative of the applicant filing this contract renewal application. The facts contained herein are true, and the applicant is in compliance with the assurances and certifications contained in the competitive RFP identified above, which is part of the original contract and any prior renewals and amendments. I understand that this contract renewal depends on the truthfulness of this document and on the applicant's continued compliance with the original contract and all its components and amendments.

13) **AUTHORIZED REPRESENTATIVE** **Check if change** ☐

Name:
Title:

14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE**

15) **DATE**

Phone: Fax: E-mail:	

FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the DSHS, including the signature of the authorized representative. It is the cover page of the renewal application and is required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original DSHS contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

1) **LEGAL NAME** - Enter the legal name of the applicant.
2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and zip code.
3) **PAYEE MAILING ADDRESS** - Enter the PAYEE's name and mailing address if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.
4) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID/SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.
5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

   HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the Texas Building and Procurement Commission (TBPC) or another entity.

   MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

   If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.
6) **CURRENTLY OPERATING UNDER A HUB SUBCONTRACTING PLAN ON FILE AT DSHS? YES OR NO** - Check the appropriate box to indicate whether or not the applicant is operating under a HUB Subcontracting Plan filed with DSHS under the original competitive RFP. If yes, the applicant must continue to comply with reporting requirements if a renewal contract is executed. Any changes to the budget which affect the HUB Subcontracting Plan must be communicated with the DSHS HUB Coordinator at 1-800-243-7487 or by e-mail at HUB-Contact@dshs.state.tx.us. If no is checked, no further action is required.
7) **PROPOSED BUDGET PERIOD** - Enter budget period as identified in this renewal application.
8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.
9) **AMOUNT OF FUNDING REQUESTED** - Enter the amount of funding requested from DSHS for proposed project activities. This amount must match column (1) row J from FORM I: BUDGET SUMMARY.
10) **PROJECTED EXPENDITURES** - If applicant's projected state or federal expenditures exceed $500,000 for applicant's current fiscal year, applicant shall arrange for a financial and compliance audit (Single Audit).
11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.
12) **FINANCIAL OFFICER** - Enter the name, title, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.
13) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and e-mail address of the person authorized to represent the applicant. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.
14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant signs in this blank.
15) **DATE** - Enter the date the person authorized to represent the applicant signed this form.

FORM B: RENEWAL APPLICATION CHECKLIST

Legal Name of Applicant: ______________________________

This form is provided to ensure that the renewal application is complete and properly signed.

FORM	DESCRIPTION	Included	Not Applicable
A	Face Page – Renewal Application completed, and proper signatures and date included	☐	
B	Renewal Application Checklist completed and included	☐	
C	Contact Person Information completed and included	☐	
D	Administrative Information for Renewal Application completed and included (with supplemental documentation attached if required)	☐	
E	Performance Measures included	☐	
F	Work Plan (only if changed) included	☐	
G	Budget Summary Form completed and included	☐	
G-1–G-6	Budget Category Detail Forms completed and included	☐	
G-7	Budget Justification in format of example completed and included	☐	
H	Nonprofit Board of Directors and Executive Director Assurances form signed and included If the signed original of this form has been provided to the Department of State Health Services during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.	☐	☐

FORM C: CONTACT PERSON INFORMATION

Legal Name of Applicant: ____________________

This form provides information about the appropriate program contacts in the applicant's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please notify the HIV/STD Comprehensive Services Branch.

Contact information	Mailing Address (incl. street, city, county, state, & zip):
Contact: ______ Title: ______ Phone: ______ Ext. ______ Fax: ______ E-mail: ______	______ ______ ______ ______
Contact: ______ Title: ______ Phone: ______ Ext. ______ Fax: ______ E-mail: ______	______ ______ ______ ______
Contact: ______ Title: ______ Phone: ______ Ext. ______ Fax: ______ E-mail: ______	______ ______ ______ ______
Contact: ______ Title: ______ Phone: ______ Ext. ______ Fax: ______ E-mail: ______	______ ______ ______ ______
Contact: ______ Title: ______ Phone: ______ Ext. ______ Fax: ______ E-mail: ______	______ ______ ______ ______

FORM D: ADMINISTRATIVE INFORMATION - Renewal Application

This form provides information regarding identification and contract history on the applicant, executive management, project management, governing board members, and/or principal officers. Respond to each request for information ***or provide the required supplemental document behind this form.*** *If responses require multiple pages, identify the supporting pages/documentation with the applicable request.*

Legal Name of Applicant: ______________________________

Identifying Information

If there are no changes to any of the items below, check here and skip the next question in this section. ☐

1. **The applicant shall attach the following information:**
   If a Governmental Entity
   - Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the applicant.

   If a Nonprofit or For profit Corporation
   - Full names (last, first, middle), addresses, telephone numbers, titles and occupation of members of the Board of Directors or any other principal officers. Indicate what offices are held by members (e.g. chairperson, president, vice-president, treasurer, etc.).
   - Full names (last, first, middle), and addresses for each partner, officer, and director as well as the full names and addresses for each person who owns five percent (5%) or more of the stock if applicant is a for profit corporation.

Conflict of Interest and Contract History

If there are no changes to any of the items below, check here and skip the questions in this section. ☐

The applicant shall disclose any existing or potential conflict of interest relative to the performance of the requirements of this renewal application. Examples of potential conflicts may include an existing business or personal relationship between the applicant, its principal, or any affiliate or subcontractor, with DSHS, the participating agencies, or any other entity or person involved in any way in any project that is the subject of this renewal application. Similarly, any personal or business relationship between the applicant, the principals, or any affiliate or subcontractor, with any employee of DSHS, a participating agency, or their respective suppliers, must be disclosed. Any such relationship that might be perceived or represented as a conflict shall be disclosed. Failure to disclose any such relationship may be cause for contract termination. If, following a review of this information, it is determined by DSHS that a conflict of interest exists, the applicant may be disqualified from further consideration for the renewal of a contract.

1. **Does anyone in the applicant organization have an existing or potential conflict of interest relative to the performance of the requirements of this renewal application?**

   ☐ **YES** ☐ **NO**

   If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)

2. **Has any member of applicant's executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the renewal application due date?**

   ☐ **YES** ☐ **NO**

   If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation.

3. **Is applicant or any member of applicant's executive management, project management, board members or principal officers:**
   - Delinquent on any state, federal or other debt;
   - Affiliated with an organization which is delinquent on any state, federal or other debt; or
   - An default on an agreed repayment schedule with any funding organization?

☐ **YES** ☐ **NO**

If YES, please explain. (Attach no more than one additional page.)

FORM E: PERFORMANCE MEASURES

In the event a contract is renewed, applicant agrees that performance measures(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements (see PERFORMANCE MEASURES Guidelines) associated with the services proposed in this renewal application. ***Additional pages may be attached if needed.***

FORM E: PERFORMANCE MEASURE Guidelines

1. Agency shall include the performance measures in the renewal application along with the proposed target levels of performance for each measure. The proposed target levels of performance and reporting frequency will be negotiated and agreed upon by the agency and DSHS.

   The agency will provide risk reduction specialist (RRS) and quality assurance training and technical assistance. This includes, but is not limited to the DSHS Prevention Counseling and Partner Elicitation (PCPE) and related protocol based counseling courses. Program goals include:

- Quality training of DSHS-funded contractors to enable them to provide HIV/STD/HCV risk reduction counseling, develop effective risk reduction plans, exhibit effective communication with clients, and provide needed links to services.
- Improve the implementation and quality assurance of individual level evidence-based interventions and linkages to group and community level interventions.
- Increase the effectiveness and efficiency of RRS, case managers, and other professionals to conduct partner services elicitations and referrals.

Agency must include the following Performance Measures and propose target levels of performance:

- Provide at least 9 protocol-based trainings to include 6 out of the Austin area and 3 in the Austin area.
- Coordinate continuing education credits for nurses, certified health education specialists, licensed chemical dependency counselors, social workers and other identified paraprofessionals.
- Coordinate scheduling of trainings and collection of applicable fees with designated DSHS staff.
- Identify additional provider needs on at least a quarterly basis.
- Provide at least eleven 3-day TA site visits outside of the Austin area and six 3-day visits within Austin area.

FORM F: WORK PLAN

Applicants shall describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments. Address the required elements (see WORK PLAN Guidelines) associated with the services proposed in this renewal application. ***Additional pages may be attached.***

FORM F: WORK PLAN Guidelines

Agency is requested to submit information *only if changed* to the following workplan elements:

1. Summarize the proposed services, population to be served, location (counties to be served), etc. Also, address if and how you will serve individuals from counties outside your stated service area.

2. Describe delivery systems, workforce (attach organizational chart), policies, support systems (i.e., training, research, technical assistance, information, financial and administrative systems) and other infrastructure available to achieve service delivery and policy-making activities. What resources do you have to perform the project, who will deliver services and how will they be delivered?

3. Describe how data is collected and tabulated, who will be responsible for data collection and reporting, and how often data collection activities will occur.

4. Describe coordination with the other providers in the service area(s) and delineate how duplication of services is to be avoided.

5. Describe ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with ADA requirements, location, hours of service delivery, and other means to ensure accessibility for the defined population).

6. Describe internal Quality Assurance/Quality Improvement (QA/QI) process utilized to monitor services, identify staff that utilize them and who is responsible for ensuring they are updated. The description shall include the following 1) role of the QA/QI Committee; 2) activities utilized to identify trends of needed improvement and the frequency of those activities; 3) activities to ensure correction and follow-up to findings identified; 4) utilization and frequency of client satisfaction surveys; 5) system utilized to identify and monitor adverse outcomes; 6) process for identifying performance and outcome measures; and 7) process utilized to develop protocols.

FORM G: BUDGET SUMMARY

Legal Name of Applicant: ______________________________

Cost Categories	DSHS Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$	$	$	$	$	$ 0
B. Fringe Benefits	$	$	$	$	$	$ 0
C. Travel	$	$	$	$	$	$ 0
D. Equipment	$	$	$	$	$	$ 0
E. Supplies	$	$	$	$	$	$ 0
F. Contractual	$	$	$	$	$	$ 0
G. Construction	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0
H. Other	$	$	$	$	$	$ 0
I. Total Direct Costs	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
J. Indirect Costs	$	$	$	$	$	$ 0
K. Total (Sum of H and I)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
L. Program Income - Projected Earnings	$	$	$	$	$	$ 0

Indirect costs are based on (mark the statement that is accurate):

☐ The applicant's most recently approved indirect cost rate _____ % A copy is attached behind the OTHER Budget Category Detail Form (FORM G-6).

☐ The applicant's most recently approved indirect cost rate _____ % which is on file with DSHS's Contract Policy & Monitoring Division.

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-DSHS state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

FORM G: BUDGET SUMMARY Instructions

An accurate budget plan is essential to achieve the performance measures and work plan set out in the narrative portion of the renewal application. All applicants shall complete the budget summary form. Be sure to refer to the appropriate sections in the renewal application for program-specific allowable and unallowable costs.

This form shall reflect funding from all sources that support the project described in this attachment. See "Detailed Budget Category Forms, General Information" for definitions of cost categories. For purposes of this form, the column headings have the following meanings:

Column 1: The amount of funds requested from the Department of State Health Services (DSHS) for this project.
Column 2: Federal funds awarded directly to applicant.
Column 3: Funds awarded to applicant from other State of Texas governmental agencies.
Column 4: Funds awarded to applicant by local governmental agencies (city, county, local health department, etc.).
Column 5: Funds from other sources not previously addressed in columns 1-4 (private foundations, donations, fund-raising, etc.).
Column 6: The sum of columns 1-5.

PROGRAM INCOME

Program Income: Projected Earnings. Applicant shall estimate the amount of program income that is expected to be generated during the budget period.

DEFINITION: Program income is the income resulting from fees or charges made by a contractor in connection with activities supported in whole or in part by a federal/state contract. Program income earned as a result of an effort which is jointly funded by DSHS and the contractor is to be shared by DSHS and the contractor. A program income allocation plan is the means by which DSHS's share is determined. The required formula for a plan is as follows:

$$\frac{\text{DSHS's Share of Funding}}{\text{DSHS's Share of Funding + Contractors Share of Funding}} \times \text{Total Program Income Collected} = \text{DSHS's Share of Program Income}$$

Contractor shall disburse program income rebates, refunds, contract settlements, audit recoveries and interest earned on such funds before requesting cash payments including advance payments from DSHS.

For more information about program income, refer to the Program Income Article in the General Provisions for DSHS Grants Contracts and/or request a copy of DSHS's Financial Administrative Procedures Manual on the Internet at http://www.tdh.state.tx.us/grants/form_doc.htm.

INSTRUCTIONS:
Projected Earnings. Applicant must enter on the BUDGET SUMMARY form the estimated amount of program income that is expected to be generated during the budget period.

Examples Of Program Income

- *Fees received for personal services performed in connection with and during the period of contract support;*
- *Tuition and fees when the course of instruction is developed, sponsored, and supported by the applicable contract from state or federal sources;*
- *Sale of services such as laboratory tests or computer time;*
- *Payments received from patients or third parties for medical or hospital service, such as Title XIX or Title XX reimbursements, insurance payments, or patient fees. These payments may be made under either a cost reimbursement or a fixed price agreement;*
- *Lease or rental of films or video tapes; and*
- *Rights or royalty payments resulting from patents or copyrights developed or acquired by the contractor.*

EXAMPLE

FORM G: BUDGET SUMMARY Example

Legal Name of Applicant: Apple County Health Department

Cost Categories	DSHS Funds Requested (1)		Direct Federal Funds (2)		Other State Agency Funds* (3)		Local Funding Sources (4)		Other Funds (5)		Total (6)	
A. Personnel	$	27,900	$	30,900	$	5,000	$	0	$	0	$	63,800
B. Fringe Benefits	$	4,032	$	5,030	$	1,000	$	0	$	0	$	10,062
C. Travel	$	1,373	$	2,070	$	5,00	$	0	$	0	$	3,448
D. Equipment	$	2,060	$	3,050	$	2,050	$	1,500	$	0	$	8,660
E. Supplies	$	45,000	$	46,000	$	20,000	$	5,500	$	0	$	116,500
F. Contractual	$	41,208	$	42,010	$	15,000	$	0	$	0	$	98,218
G. Construction	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
H. Other	$	23,000	$	1,000	$	500	$	0	$	0	$	24,500
I. Total Direct Costs	$	144,573	$	130,060	$	44,050	$	7,000	$	0	$	325,683
J. Indirect Costs	$	2,025	$	900	$	650	$	0	$	0	$	3,575
K. Total (Sum of H and I)	$	146,598	$	130,960	$	44,700	$	7,000	$	0	$	329,258
L. Program Income	$	13,200	$	12,000	$	4,200	$	600	$	0	$	30,000

Indirect costs are based on (mark the statement that is accurate):

[x] The applicant's most recently approved indirect cost rate 7 % A copy is attached behind the OTHER Budget Category Detail Form (FORM G-6).

[ ] The applicant's most recently approved indirect cost rate ____ % which is on file with DSHS's Contract Policy & Monitoring Division.

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-DSHS state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

DETAILED BUDGET CATEGORY FORMS

General Information

Requirements for Categorical Budgets

The renewal application shall include a detailed breakdown of budget cost categories and a narrative justification. Details of each cost category shall be expressed using the budget category detail forms (G-1 to G-6), which follow. Definitions of the cost categories and instructions and examples of how to itemize the contents of each cost category are included after the budget category detail forms. Computer generated facsimiles may be substituted for any of the forms; however, the exact wording and format must be maintained.

General Information

Additional information on basic accounting and financial management systems requirements is available in DSHS's Financial Administrative Procedures Manual. Copies of the manual are available on the Internet at http://www.tdh.state.tx.us/grants/form_doc.htm.

Only those costs allowable under UGMS and any revisions thereto plus any applicable federal cost principles are eligible for reimbursement under this contract. Applicable cost principles, audit requirements, and administrative requirements are as follows:

Applicable Cost Principles	Audit Requirements	Administrative Requirements
OMB Circular A-87, State & Local Governments	OMB Circular A-133	UGMS
OMB Circular A-21, Educational Institutions	OMB Circular A-133	OMB Circular A-110
OMB Circular A-122, Non Profit Organizations	OMB Circular A-133 and UGMS	UGMS
48 CFR Part 31, For Profit Organization and other than a hospital and an organization named in OMB Circular A-122 as not subject to that circular	Program audit conducted by an independent certified public accountant must be in accordance with Governmental Auditing Standards.	

A. Allowable and Unallowable Costs

Below is a brief listing of allowable and unallowable costs as prescribed by federal cost principles or DSHS policy. Applicable federal cost principles provide additional information and guidance on allowable and unallowable costs.

An **allowable cost**, in accordance with federal cost principles, meets the following criteria:

1. It is necessary and reasonable for proper and efficient administration of the funded program;
2. It can be allocated to the funded program and is not a general expense needed to carry out the contractor's general responsibilities;
3. It is authorized or is not prohibited under applicable laws or regulations;
4. It conforms to applicable limitations or exclusions;
5. It is consistent with applicable policies and procedures;
6. It is treated consistently through the renewal application of generally accepted accounting principles appropriate to the circumstances;
7. It is not allocated or included as a cost of any other program; and
8. It is the net sum of all applicable credits.

Unallowable costs, i.e., costs that may not be paid with DSHS funds include, but are not limited to:

1. Advertising and public relations costs other than those specifically allowed by terms of the contract attachment or those incurred for the purpose of personnel recruitment, solicitation of bids and disposal of surplus materials;
2. Bad debts;
3. Construction is not allowed without the prior written approval of DSHS;
4. Contingency reserve funds;
5. Contributions and donations;
6. Entertainment costs including amusement/social activities and their related costs (meals, beverages, lodgings, rentals, transportation, and gratuities) are not allowed unless the costs are directly related to the program's purpose and DSHS has reviewed and issued prior written approval of the work plan components that relate to entertainment costs;
7. Fines, penalties, late payment fees, bank overdraft charges;
8. Fundraising;
9. Interest (unless specifically authorized by applicable cost principles or authorized by federal or state legislation);
10. Lobbying.

B. <u>Direct Costs</u>

Direct costs are those that can be specifically identified with a particular award, project, service, scope of work or other direct objective of an organization. These costs may be charged directly to the DSHS contract attachment (if contract is renewed). These costs may also be charged to cost objectives used to accumulate all costs pending distribution to specific contracts and other purposes. Direct cost categories include: personnel, fringe benefits, travel, equipment, supplies, contractual, and other.

C. <u>Indirect Costs</u>

Indirect costs are those costs related to the project that are not included in direct costs. Indirect costs are those costs incurred for a common or joint purpose benefiting more than one cost objective and not readily identified with a particular cost center and which may be paid if allowable under the funding source, e.g., depreciation and use allowances, interest, operation and maintenance expenses (janitorial and utility services, repairs and normal alterations of buildings, furniture, equipment, care of grounds, security), general administration and general expenses (central offices such as director, office of finance, business services, budget and planning, personnel, general counsel, safety and risk management, management information services).

The amount of indirect costs that may be charged to any resulting DSHS contract attachment is determined by negotiation and will be defined in the contract budget attachment. The applicant may negotiate an indirect cost rate with its federal cognizant agency or state-coordinating agency or develop a cost allocation plan that is kept on file and made available during compliance reviews.

D. <u>Audit Requirements</u>

If required by OMB Circular A-133 and/or UGMS, applicant or applicant's authorized contracting entity shall arrange for a financial and compliance audit (Single Audit). Applicant may include in the budget request an amount for DSHS's proportionate share of costs. The audit must be conducted by an independent CPA and must be in accordance with applicable OMB Circulars, Government Auditing Standards, and UGMS. Audit services shall be procured in compliance with state procurement procedures, as well as the provisions of UGMS.

FORM G-1: PERSONNEL Budget Category Detail Form

Legal Name of Applicant: ______________________________

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required. Note: Applicant is responsible for understanding the potential impact of alternative Fringe Benefit options.

Salary Total	$ 0
Fringe Benefit Rate %	%
FRINGE BENEFITS TOTAL	$

EXAMPLE ORM G-1: PERSONNEL Budget Category Detail Form Example

Legal Name of Applicant: Apple County Health Department

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification
Financial Officer (E)	5%		$42,000	$2,100	N	Provides financial accountability of program
Administrative/Personnel (P)	5%		$36,000	$1,800	Y	Provides personnel services and training
Outreach Counselor (E)	100%		$24,000	$24,000	N	Provides outreach/case management services

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required. Note: Applicant is responsible for understanding the potential impact of alternative Fringe Benefit options.	Salary Total	$27,900
FICA 7.65% Worker's Comp 2.05% Retirement Plan 1.63% Health Insurance 3.12%	Fringe Benefit Rate 14.45 % FRINGE BENEFITS TOTAL	$4,032

PERSONNEL

DEFINITION: The actual cost of salaries and wages paid to employees of the organization devoted to the DSHS funded project. These costs are allowable to the extent that they are reasonable and conform to the established, consistently applied policy of the organization and reflect no more than the time actually devoted to the project.

INSTRUCTIONS: Enter the following information for each position on the PERSONNEL Budget Category Detail Form: functional title, whether the position is existing or proposed, % of time dedicated to the project, any certification or license an individual must possess to be qualified for the position, the total annual salary, the amount of DSHS funds requested for this position's salary (% of time dedicated to the project multiplied by the annual salary), whether the position is vacant or filled, and the justification for the position. Justification may include a brief description of the position's primary responsibilities and an explanation for the % of time dedicated to the project, why the position classification is appropriate (including license/certification requirements), and an explanation of reasonableness of the annual salary.

FRINGE BENEFITS

DEFINITION: Fringe benefits are allowances and services provided by the organization to their employees as compensation in addition to regular salaries and wages. Fringe benefits include but are not limited to the cost of leave, employee insurance, pensions, and unemployment benefit plans. The cost of fringe benefits is allowable (in proportion to the amount of time or effort employees devote to the grant funded project), to the extent that the benefits are reasonable and are incurred under formally established and consistently applied policies of the organization. Note: Applicant is responsible for understanding the potential impact of alternative Fringe Benefit practices.

INSTRUCTIONS: Itemize the elements of fringe benefits and indicate the % rate on the PERSONNEL Budget Category Detail Form.

FORM G-2: TRAVEL Budget Category Detail Form

Legal Name of Applicant: ______________________________

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$		$	$	$ 0	

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom DSHS funds are requested)	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
							0	
							0	
							0	
							0	
							0	
							0	
		TOTAL for Conf/Workshop TRAVEL:	$ 0		$ 0	$ 0	$ 0	

Local TRAVEL Costs: $ 0	Conf/Workshop TRAVEL Costs: $ 0	Total TRAVEL Costs: $ 0

NOTE: All contracts with the Department of State Health Services require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, DSHS's travel policy will be used.

EXAMPLE

FORM G-2: TRAVEL Budget Category Detail Form Example

Legal Name of Applicant: Apple County Health Department

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$ .405	1,068	$ 433	$ 144	$ 577	Executive Director – Travel to all site locations in the nineteen county area for review, monitor, evaluate, and oversee clinic operations.

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom DSHS funds	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
Family Planning Advisory Committee Meetings (4)	Austin	1	1,735 miles x $0.405/mile =	$703	$432	$0	$1,135	Clinic Services Director to attend Family Planning Committee meetings (4)
		TOTAL for Conf/Workshop TRAVEL:		$703	$432	$0	$1,135	

Local TRAVEL Costs:	$577	Conf/Workshop TRAVEL Costs:	$1,135	Total TRAVEL Costs:	$1,712

NOTE: All contracts with the Department of State Health Services require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, DSHS's travel policy will be used.

TRAVEL

DEFINITION: The costs of transportation, lodging, meals and related expenses incurred by employees of the organization while performing duties relevant to the proposed project. This includes auto mileage paid to employees on the basis of a fixed mileage rate for the use of their personal vehicle. Costs related to client transportation and registration fees should be classified as "Other" expense category. Travel costs incurred by a third party under contract should be included within the terms of the contract and be budgeted under "Contractual" expense category.

INSTRUCTIONS: The TRAVEL Budget Category Detail Form requires information on local travel costs (travel and per diem) and information on conferences/workshops for which DSHS funding is being requested. For local travel, enter the reimbursement rate for automobile mileage and the estimated number of miles to be traveled for the budget period. To calculate the total estimated local travel costs, multiply the local reimbursement rate per mile by the total estimated number of automobile miles. Enter the estimated per diem costs which may be associated with local travel and show the basis for cost (15 partial days x $7 per partial day = $105). The justification should include who or what position classification(s) will be traveling and why local travel is necessary to accomplish the project. For conferences/workshops, the following must be included for all attending for whom DSHS funds are being requested: the name and/or description of the conference/workshop, the location (city), the number of persons attending, estimated travel, per diem, other related travel costs (excluding registration fees) and total costs for all attending. The justification should include how attendance at the conference/workshop will directly benefit the project and why it is necessary to accomplish the project.

FORM G-3: EQUIPMENT Budget Category Detail Form

Legal Name of Applicant: ______________________________

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached sample for equipment definition and detailed instructions to complete this form.

DESCRIPTION OF ITEM (= $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for EQUIPMENT:		$ 0.00	

SAMPLE

FORM G-3: EQUIPMENT Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order.

DESCRIPTION OF ITEM (= $5,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
PhoneMaster Professional Autodialing Voice Organization-to-Client Communication System, with 2 year warranty	$5,250/1	$5,250	Phone system will confirm appointments and make autodial phone calls for outreach events. Reduction in staff time for follow-up calls and reduction in marketing/advertising expenses.
TOTAL Amount Requested for EQUIPMENT:		$ 5,250	

EQUIPMENT

DEFINITION: Equipment is defined by DSHS as non-expendable personal property with a unit cost of more than $5,000.00 and a useful life of more than one year, with the following exceptions: fax machines, stereo systems, cameras, video recorders/players, microcomputers, printers, software, medical and laboratory equipment. Medical and laboratory equipment in this category is defined as microscopes, oscilloscopes, centrifuges, balances, and incubators. Medical and laboratory equipment not included in these five categories are not considered a capital asset unless the unit value is over $5,000.00. The exception items listed will still be inventoried if their unit cost plus any items used with or attached to the unit is $500.00 or greater. For items with component parts (i.e., computers), the aggregate cost must be considered when applying the $500/$5,000 threshold.

INSTRUCTIONS: Enter the following information on the EQUIPMENT Budget Category Detail Form for each type of equipment item: description of each item, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), state the purpose for the item(s) and why the equipment is necessary and how the applicant determined or will determine that the cost is reasonable. Attach a complete specification or a copy of the purchase order.

EXAMPLES OF EQUIPMENT DESCRIPTIONS

Remember: Equipment is priced **per unit** including freight. If you intend to purchase 10 modems @ $95 each, this would be considered a supply item not an equipment item.

INCORRECT EXAMPLES	CORRECT EXAMPLES
Computer-850 Mhz Pentium 1 @ $2,150 *(insufficient description/specification)* 1 @ $250 Laser Jet Printer *(This item would be moved to supplies as it is less than $500.00).*	Laptop Computer Dell Inspiron 8000, Intel Pentium III Processor at 850 MHz, .32 KB Internal Cache (L1), 100 MHZ (Pentium III) external BUS, Frequency and 66 MHZ (Celeron) external BUS frequency Intel 815e AGP, Set Chipset with 4X AFP memory. 1 @ $2,150 24" Zenith Portable TV/VCR Combination; Model #Z12345 1 @ $750

FORM G-4: SUPPLIES Budget Category Detail Form

Legal Name of Applicant: ______________________________

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (i.e., office, computer, medical, educational, janitorial, etc.). See attached sample for definition of supplies and detailed instructions to complete this form.

DESCRIPTION OF ITEM (= $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
	TOTAL Amount Requested for SUPPLIES:	$ 0.00	

SAMPLE **FORM G-4: SUPPLIES Budget Category Detail Form Sample**

Legal Name of Applicant: Apple County Health Department

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (i.e., office, computer, medical, educational, janitorial, etc.).

DESCRIPTION OF ITEM (= $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
Office supplies	$750/month / 12 months	$9,000	Consumable items needed to support Family Planning clinic services; no item has a unit cost greater than $499.
Pharmaceuticals	$2,500/month / 12 months	$30,000	Consumable items needed to support Family Planning clinic services; no item has a unit cost greater than $499.
	TOTAL Amount Requested for SUPPLIES:	$ 39,000	

SUPPLIES

DEFINITION: Costs for materials and supplies necessary to carry out the program. This includes medical supplies, drugs, janitorial supplies, office supplies, patient educational supplies, software less than $500, plus any equipment or furniture with a purchase price including freight not to exceed $5,000 per item, except those listed in the "equipment" category.

INSTRUCTIONS: Enter the following information in the SUPPLIES Budget Category Detail Form for each general category or type of supplies: description of the items, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), and state the purpose for the item(s), why the supplies are necessary and how the applicant determined or will determine that the cost is reasonable.

FORM G-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Applicant: ____________________

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION

TOTAL Amount Requested for CONTRACTUAL: $ 0

EXAMPLE **FORM G-5: CONTRACTUAL Budget Category Detail Form Example**

Legal Name of Applicant: Apple County Health Department

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION
Dr. Bob Health, D.O.	Oversees medical services	Unit Cost	month	$300	$3,600	Medical Director required by DSHS
Dr. Peter Paul, D.O.	Provides health history & physicals	Unit Cost	130 hours/ month	$3,034	$36,408	Contract physician at clinics performing medical exams
Dr. Billy Bob, D.O.	Provide professional guidance	Cost Reimburse	N/A	N/A	$1,200	Medical Consultant
				TOTAL Amount Requested for CONTRACTUAL:	$ 41,208	

CONTRACTUAL

DEFINITION: Activities identified in the scope of work that are delegated by the applicant to a third party; the cost of providing these activities is recorded in this category. Travel costs incurred by a third party while performing these activities should be included in this category. Contracts for administrative services are not included in this category; they are properly classified in the "Other " category.

If the applicant enters into grant contracts with subrecipients or procurement contracts with vendors, the documents will be in writing and will comply with the requirements specified in the Contracts with Subrecipients and Contracts for Procurement articles in the General Provisions for Department of State Health Services Grant Contracts which are available online at http://www.tdh.state.tx.us/grants/form_doc.htm.

If an applicant plans to enter into a contract which delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, the applicant must submit justification to DSHS and receive prior written approval from DSHS before entering into the contract.

INSTRUCTIONS: The CONTRACTUAL Budget Category Detail Form requires names of the individuals or organizations performing the services, a description of the services being contracted, the number of hours or units of service to be purchased, the method of reimbursement (cost reimbursement or unit cost), unit cost if applicable and total amount of each subcontract. Justification should include why applicant intends to contract for the service, why the service is necessary to perform the scope of work and how the applicant will ensure that the cost of the service is reasonable.

Justification for contracts that delegate a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, must be attached behind the CONTRACTUAL Budget Category Detail Form.

FORM G-6: OTHER Budget Category Detail Form

Legal Name of Applicant: ______________________________

DESCRIPTION	(# of units x unit cost if applicable)	COST	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for OTHER:	$ 0

EXAMPLE

FORM G-6: OTHER Budget Category Detail Form Example

Legal Name of Applicant: Apple County Health Department

DESCRIPTION	# of units x unit cost if applicable	COST	PURPOSE & JUSTIFICATION
Telephone (23 lines)	12 months x $833.34 =	$10,000	Telephone service
Printing	12 months x $666.67 =	$8,000	Documents, forms, letters, and literature
Single Audit	1 x $5,000 =	$5,000	Single Audit (DSHS requirement)
TOTAL Amount Requested for OTHER:	$	23,000	

OTHER
DEFINITION: All other allowable direct costs not listed in any of the above categories are to be included in this category. Some of the major costs that should be budgeted in this category are:

* contracts for administrative services;
* space and equipment rental;
* utilities and telephone expenses;
* data processing services;
* printing and reproduction expenses;
* postage and shipping;
* contract clerical or other personnel services;
* janitorial services;
* exterminating services;
* security services;
* insurance and bonds;
* equipment repairs or service maintenance agreements;
* books, periodicals, pamphlets, and memberships;
* advertising;
* registration fees;
* patient transportation;
* training costs, speakers fees and stipends.
* software less than $500

INSTRUCTIONS: The OTHER Budget Category Detail Form requires a general description of the service, and the cost. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity. The justification should also include a statement of when services will be utilized if other than the full renewal application budget period.

FORM G-7: CATEGORICAL BUDGET JUSTIFICATION

Agency must submit a categorical budget justification for proposed services. Submitted budget must include the following categories: Personnel, Fringe, Travel, Equipment, Supplies, Contractual, Other, Total Direct Costs, Indirect Costs, and Total Budget. Additionally, items listed in the budget must bear a brief justification describing what is to be purchased. For example, under the personnel category, list each position and provide a brief job description of 50 words or less. Also, for each position listed, multiply the monthly salary or wages by the percentage of personnel time by the number of months the salary is to be paid from this budget. Additional pages may be attached as needed.

FORM H: NONPROFIT BOARD OF DIRECTORS AND EXECUTIVE DIRECTOR ASSURANCES FORM

If the applicant is a nonprofit organization, this form must be completed (state or other governmental agencies are not required to complete this form). The purpose of the form is to inform nonprofit board members and officers of the responsibilities and administrative oversight requirements of nonprofit applicants intending to or contracting with Department of State Health Services (DSHS).

____

____

____

____

(Name & Address Of Organization)

The persons signing on behalf of the above named organization certify that they are duly authorized to sign this Assurances form on behalf of the organization. The undersigned acknowledge and affirm:

A. That an annual budget has been approved for each contract with DSHS.

B. The Board of Directors convenes on a regularly scheduled basis (no less than quarterly) to discuss the operations of the organization.

C. Actual revenue and expenses are compared with the approved budget, variances are noted, and corrective action taken as needed (with Board approval).

D. Timely and accurate financial statements are presented by the designated financial officer on a regular basis to the board.

E. That the Board of Directors will ensure that any required financial reports and forms, whether federal or state, are filed on a current and timely basis.

F. Adequate internal controls are in place to ensure fiscal integrity and accountability and to safeguard assets.

G. The Treasurer of the Board has been fully informed of his or her responsibilities as Treasurer.

H. The Board has Audit and/or Finance Committees that convene regularly and communicate effectively with the Board Treasurer and other Board members in understanding and responding to financial developments.

I. The organization observes Generally Accepted Accounting Principles when preparing financial statements and fund accounting practices are observed to ensure integrity among specific contracts or grants.

J. If a contract is executed with DSHS, this form will be discussed in detail at the next official Board meeting and that notes of the discussion and a signed copy of this form will be included in the minutes of the meeting. A copy of the minutes will be kept at the organization and be available for inspection by DSHS staff.

K. If a contract is executed with the DSHS and the nonprofit organization has not received any funding from DSHS for the past 24 months, the Legal and Fiscal Responsibilities for Nonprofit Board of Directors Video and Guide will be viewed and a signed "tear-out" sheet will be completed and filed by each board member with the nonprofit organization no later than 45 days after contract execution. Newly appointed/elected board members will comply with these requirements no more than 45 days after taking office. All tear-out sheets will be available for inspection by DSHS staff.

L. The organization will administer any contract executed with the DSHS in accordance with applicable federal statutes and regulations, including federal grant requirements applicable to funding sources, Uniform Grant Management Standards issued by the Governor's Office, applicable Office of Management and Budget Circulars, applicable Code of Federal Regulations, and provisions of the contract document.

______________________________	______________________________
***Chairman of the Board Signature/Date**	***President or Executive Director Signature/Date**

*If the signed original of this form has been provided to DSHS during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.