



Renewal Application For Financial Management Assistance for Texas HIV/STD Community Planning Groups

www.tdh.state.tx.us/hivstd

RFP HIV-CPPREV 0119.2

Issue Date: *07/15/2005*

Due Date: *08/29/2005*

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 Department of State Health Services (DSHS) HIV/STD Comprehensive Services Branch announces the expected availability of calendar year 2006 funding for the provision of financial management services to the six Texas HIV/STD prevention community planning groups (CPGs). Current DSHS contractors receiving funds under Request For Proposal (RFP) to Secure Financial Management Assistance for Texas HIV/STD Community Planning Groups, issued 10/20/04, RFP HIV-CPPREV 0119.1, 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 08/29/05.**

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.bennett@dshs.state.tx.us

RFP # : **HIV-CPPREV 0119.2**

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-CPPREV 0119.2

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.

ORGANIZATION AND CONTENT

III. RENEWAL APPLICATION ORGANIZATION AND CONTENT

The renewal application should be organized in the following order:

- A. Face Page - Renewal Application as authorized under *RFP to Secure Financial Management Assistance for Texas HIV/STD Community Planning Groups*, issued 10/20/04, RFP HIV-CPPREV 0119.1
- 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 RFP to Secure Financial Management Assistance for Texas HIV/STD Community Planning Groups, issued 10/20/04, RFP HIV-

CPPREV 0119.1

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 <input type="checkbox"/>
3) PAYEE Mailing Address (if different from above):	
Check if address change <input type="checkbox"/>	
4) Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or Social Security Number (9 digit) : <i>*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 request s.</i>	
5) TYPE OF ENTITY (check all that apply):	
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Other Political Subdivision <input type="checkbox"/> State Agency <input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Nonprofit Organization* <input type="checkbox"/> For Profit Organization* <input type="checkbox"/> HUB Certified <input type="checkbox"/> Community -Based Organization <input type="checkbox"/> Minority Organization
<input type="checkbox"/> Individual <input type="checkbox"/> FOHC <input type="checkbox"/> State Controlled Institution of Higher Learning <input type="checkbox"/> Hospital <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): _____	
<i>*If incorporated, provide 10-digit charter number assigned by Secretary of State:</i>	
6) Currently operating under a HUB Subcontracting plan on file at DSHS? Yes <input type="checkbox"/> No <input type="checkbox"/>	
7) PROPOSED BUDGET PERIOD:	Start Date: _____ End Date: _____
8) COUNTIES SERVED BY PROJECT:	
9) AMOUNT OF FUNDING REQUESTED:	11) PROJECT CONTACT PERSON
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 <input type="checkbox"/> No <input type="checkbox"/> <i>**Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.</i>	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 <input type="checkbox"/> Name: _____ Title: _____	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE
	15) DATE

Phone:

Fax:

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	<input type="checkbox"/>	
B	Renewal Application Checklist completed and included	<input type="checkbox"/>	
C	Contact Person Information completed and included	<input type="checkbox"/>	
D	Administrative Information for Renewal Application completed and included (with supplemental documentation attached if required)	<input type="checkbox"/>	
E	Performance Measures included	<input type="checkbox"/>	
F	Work Plan included	<input type="checkbox"/>	
G	Budget Summary Form completed and included	<input type="checkbox"/>	
G-1-G-6	Budget Category Detail Forms completed and included	<input type="checkbox"/>	
G-7	Budget Justification in format of example completed and included	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>

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

All agencies must include the following objectives:

- Reimburse 90% of CPG-related expenditures within 30 days of the receipt of the agency's acceptable invoice or voucher.
- Provide one (1) training session to CPG members regarding policies and procedures for documenting and requesting reimbursement within 45 days of contract start date.
- Provide quarterly reports in the format provided by DSHS to DSHS staff on or before April 20, 2006, July 20, 2006, October 20, 2006, and January 20, 2007.
- Provide summarized expenditure reports to CPG co-chairs using a format approved by DSHS and a reporting schedule to be negotiated with DSHS and the co-chairs.

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

1. Describe changes to project staff. Include the qualifications of any new staff added to the project.
2. Describe any changes to mechanisms for reimbursing CPG members within 30 days after agency's receipt of acceptable invoices or vouchers that appear sufficient.
3. Describe changes to the agency's policies and procedures related to financial management including cash advance policies.
4. Describe any changes to procedures for submitting vouchers to DSHS on a monthly basis.

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
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:

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

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.

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):

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.

**DETAILED BUDGET CATEGORY FORMS,
Allowable/Unallowable Costs continued**

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. Direct Costs

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. Indirect Costs

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. Audit Requirements

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.

EXAMPLE CRM 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%				Fringe Benefit Rate 14.45 %		
Worker's Comp 2.05%				FRINGE BENEFITS TOTAL		\$4,032
Retirement Plan 1.63%						
Health Insurance 3.12%						

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
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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:	\$1,373
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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

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).

CORRECT EXAMPLES

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
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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	

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

All agencies must provide a categorical budget justification for proposed services. Budgets must reflect the cost for the applicant to administer the financial services, as well as the costs associated with reimbursing CPGs. Costs associated with reimbursing CPGs should be reflected in the "Other" category. Please refer to the sample on the following page when constructing Categorical Budget Justifications. Agencies serving more than one plan area must submit a separate budget justification for each plan area. Additional pages may be attached as needed. Please note that plans for approved expenditures of funds from the Other budget category (aka CPG Expenditure plan) will be negotiated prior to contract start date.

FORM G-7: CATEGORICAL BUDGET JUSTIFICATION EXAMPLE

SAMPLE		
HIV/STD Community Planning Group Banker Budget		
Budget Categories	Budget Detail	Total Budget
A. Personnel (direct salary)		4,500
John Smith 10 % time x 45,000 annual salary	4,500	
B. Fringe Benefits		1,125
25% of salary x 45,000 x 10% of time	1,125	
C. Travel		200
4 trips to CPG meetings to provide TA and reports <i>Mileage: _____ miles x 0.405/mile x # _____ of trips</i> <i>Lodging: _____ nights x \$85/night x # _____ of trips</i> <i>Per Diem: _____ days x \$36/day x # _____ of trips</i>		
D. Supplies		
General Office Supplies	300	300
E. Other		21,076
1. CPG-related expenditures (e.g. travel reimbursement, needs assessment expenditures, supplies, postage, meeting expenses, translation services, conference registration)	20,626	
2. Administrative costs (cost allocation plan required)	450	
F. Total Direct Costs		27,201
G. Indirect Costs (only if approved rate exists)		0
H. Total Costs		27,201

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.