APPENDIX E: FIXED RATE BUDGET

FIXED RATE CONTRACT #20-008 TAXPAYER ID# _____

Agency: _____ **Address:** _____

_____

Project Title: **Comprehensive Family Support Services Program (CFSSP)**

Budget Period: **October 01, 2009** **to** **September 30, 2011**

The parties hereto agree that the contract reimbursement shall not exceed the cost/rate set out below.

SERVICES	RATE PER Unit		ELIGIBLE UNITS PER YEAR	TOTAL COST
CFSSP	_____	**X**	**300 UNITS**	_____

Reimbursement is at a fixed rate.

CFSSP contract not to exceed 300 units (A unit is a family) per year.

Care days less than 16 days will be billed as ½ Unit.

If provider exceeds contracted units prior to the end of the contract period, the provider agrees to continue services through the contract period at no additional cost to DHR.

The County/State Department will make payment for the actual number of eligible units of service provided during the calendar month.

Total expenditures under this contract shall not exceed the Grand Total set out above.

List site addresses if more than one: **Covington County**

Budget Recap of Expenses

I. Personnel:

A. Salaries _____
B. Fringe Benefits: _____

II. Subcontracted Services:

A. Consultants: _____
B. Audit Service: _____
C. Other (Identify) _____

III. Travel:

A. Mileage (Show rate of Reimbursement) _____
B. Per Diem (Show Rate of Reimbursement) _____

IV. Space:

A. Telephone _____
B. Rent (include copy of lease) _____
C. Use Allowance (No More than 2% of Acquisition Cost/Year) _____
D. Rental Rate System _____
E. Utilities _____
F. Maintenance of Building/Grounds _____
G. Minor Repairs to Building _____

V. Supplies:

A. Office _____
B. Household _____
C. Recreational _____
D. Educational _____
E. Medical _____
F. Personal Care _____

VI. Equipment:

A. Rental (include rental agreement) _____
B. Repair _____
C. Depreciation _____

VII. Other:

A. Insurance _____
B. Vehicle Operation _____

C. Taxes _____
C. Food in Excess of USDA _____
D. Other Allowable Costs, _____
Specify General
Categories: _____

VIII. Total Program Cost: _____

IX. Program Income: Please report all income from all sources available to your program. (Detail Sources)

_____ _____ _____
_____ _____ _____
_____ _____ _____

X. Client Date:

A. Potential Units of Service (Multiply License Capacity by Days in Year.) _____
B. DHR Eligible Units of Service _____
C. Ineligible Units of Service _____

XI. Rate of Information:

A. Proposed_____ Families served at $_____ Fixed Rate per family for

$_____ Total Allocation