Budget Narrative Form – Oral Disease & Injury Prevention Program

SALARIES/WAGES

Position Title and Name	Annual Salary	Time	Months	DHMH Amount Requested	Total Amount

TOTAL DHMH SALARIES/WAGES AMOUNT REQUESTED $_____

Summary Justification:

FRINGE BENEFITS

Fringe Benefit	Percentage of Salary	DHMH Amount Requested	Total Amount
Retirement			
FICA			
Insurance			
Workers Compensation			

Fringe Benefit	Percentage of Salary	DHMH Amount Requested	Total Amount
Retirement			
FICA			
Insurance			
Workers Compensation			

Fringe Benefit	Percentage of Salary	DHMH Amount Requested	Total Amount
Retirement			
FICA			
Insurance			
Workers Compensation			

TOTAL DHMH FRINGE BENEFITS AMOUNT REQUESTED $_____

CONSULTANT COSTS

1. Name of Consultant: _____
   Organizational Affiliation (if applicable): _____
   Nature of Services to Be Rendered: _____
   Relevance of Service to the Project: _____
   Number of Days of Consultation (basis for fee): _____
   Expected Rate of Compensation: _____
   Method of Accountability: _____
   _____
   _____

2. Name of Consultant: _____
   Organizational Affiliation (if applicable): _____
   Nature of Services to Be Rendered: _____
   Relevance of Service to the Project: _____
   Number of Days of Consultation (basis for fee): _____
   Expected Rate of Compensation: _____
   Method of Accountability: _____
   _____
   _____

3. Name of Consultant: _____
   Organizational Affiliation (if applicable): _____
   Nature of Services to Be Rendered: _____
   Relevance of Service to the Project: _____
   Number of Days of Consultation (basis for fee): _____
   Expected Rate of Compensation: _____
   Method of Accountability: _____
   _____
   _____

Name of Consultant	Organizational Affiliation	Expected Rate of Compensation	DHMH Amount Requested	Total Amount

TOTAL DHMH CONSULTANT COSTS REQUESTED $_____

EQUIPMENT

Item Requested	Number Needed	Unit Cost	DHMH Amount Requested	Total Amount

TOTAL DHMH EQUIPMENT REQUESTED **$_____**

Summary Justification:

SUPPLIES

Item Requested	Number Needed	DHMH Amount Requested	Total Amount

TOTAL DHMH SUPPLIES REQUESTED **$_____**

Summary Justification:

TRAVEL-In-State Only

Number of Trips	Number of People	Number of Total Miles	Cost per Mile	DHMH Amount Requested	Total Amount

TOTAL DHMH TRAVEL REQUESTED **$_____**

Summary Justification:

OTHER

Item Requested	Number Needed	DHMH Amount Requested	Total Amount

TOTAL DHMH OTHER REQUESTED **$_____**

Summary Justification:

CONTRACTUAL COSTS

1. Name of Contractor: _____
   Method of Selection: _____
   Period of Performance: _____
   Scope of Work: _____
   Method of Accountability: _____
   Itemized Budget and Justification: _____
   _____
   _____
   _____

2. Name of Contractor: _____
   Method of Selection: _____
   Period of Performance: _____
   Scope of Work: _____
   Method of Accountability: _____
   Itemized Budget and Justification: _____
   _____
   _____
   _____

3. Name of Contractor: _____
   Method of Selection: _____
   Period of Performance: _____
   Scope of Work: _____
   Method of Accountability: _____
   Itemized Budget and Justification: _____
   _____

_____
_____

Contractual Items	Name of Organization	DHMH Amount Requested	Total Amount

TOTAL DHMH CONTRACTUAL COSTS REQUESTED $_____

<u>DHMH COSTS REQUESTED</u>

DHMH SALARIES/WAGES REQUESTED $_____

DHMH FRINGE BENEFITS REQUESTED $_____

DHMH CONSULTANT COSTS REQUESTED $_____

DHMH EQUIPMENT REQUESTED $_____

DHMH SUPPLIES REQUESTED $_____

DHMH TRAVEL REQUESTED $_____

DHMH OTHER REQUESTED $_____

DHMH CONTRACTUAL COSTS REQUESTED $_____

TOTAL DHMH DIRECT COSTS REQUESTED $_____

TOTAL DHMH INDIRECT COSTS REQUESTED $_____

TOTAL DHMH DIRECT AND INDIRECT COSTS REQUESTED $_____