STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HUMAN SERVICES CONTRACT PROPOSAL

A. Vendor Information: ______________________________

Organization: ______________________________

Address: ______________________________

City: ____________________ **State:** __________ **Zip Code:** __________

Contact Person: ____________________ **Telephone:** ____________________

Mailing Address (if other than shown above): ______________________________

Federal Employer I.D.: ____________________ **Minority Enterprise** 9 Yes 9 No

Fiscal Year or Period for which Funds are Requested: ______________________________

Type of Service To Be Funded: ______________________________

Performance Measures Detail Attached 9 Yes 9 No

Area/Jurisdiction To Be Serviced: ______________________________

Does the Organization Do Fundraising: 9 Yes 9 No

Are any of the State supported costs being used to generate fundraising dollars 9 Yes 9 No

Type of Proposal: 9 New 9 One-Time Only 9 Renewal 9 Supplement

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B. Affirmations and Signature of Certifying Official: (Mark Appropriate Box(es))

If the local health officer has not signed below, a copy of this application was sent to that official simultaneously with this submission

A program narrative is attached for each service.

On behalf of the governing board or other executive authority of the above named organization, I affirm that the information and estimates conveyed in this application are true and accurate to the best of my knowledge.

Signature: ____________________ **Date:** ____________________

Name Printed or Typed: ____________________ **Title:** ____________________

C. Third Party Review:

Reviewing Official	Signature	Date	Reviewed	Approved	Disapproved	Attached
Local Health Officer						
Advisory Council						
Local Govt. Auth.						
Regional Director						
Other (Specify)						

D. For DHMH Use Only ______________________________

DHMH 432A (Rev. Feb. 1997)

PROGRAM BUDGET

PROGRAM ADMINISTRATION: ______________________________
GRANT NUMBER: ____________________ DATE SUBMITTED: ____________
CONTRACT PERIOD: ______________ FISCAL YEAR: ____________
ORGANIZATION: ____________________ PHONE #: ____________
STREET ADDRESS: ______________________________
CITY, STATE, COUNTY: ____________________ ZIP: ________
PROGRAM TITLE: ______________________________
CHARGEABLE SERVICES (Y/N) ________ DHMH PROVIDES 50% OR MORE OF FUNDING (Y/N)
FOR DHMH USE ONLY ______________________________

			OTHER DIRECT FUNDING			
LINE ITEMS MAY NOT BE CHANGED	DHMH FUNDING REQUEST	SUPPLEMENTAL FUNDING REDUCTION	FED./STATE LOCAL & GOV'T	ALL OTHER AGENCY	TOTAL OTHER FUNDING	PROGRAM BUDGET
SALARIES/SPECIAL PAYMENTS						
FRINGE						
CONSULTANTS						
EQUIPMENT						
PURCHASE OF SERVICE						
RENOVATION						
CONSTRUCTION						
REAL PROPERTY PURCHASE						
UTILITIES						
RENT						
FOOD						
MEDICINES & DRUGS						
MEDICAL SUPPLIES						
OFFICE SUPPLIES						
TRANSPORTATION/TRAVEL						
HOUSEKEEPING/ MAINTENANCE/REPAIRS						
POSTAGE						
PRINTING/DUPLICATION						
STAFF DEVELOPMENT/ TRAINING						
CLIENT ACTIVITIES						
ADVERTISING						
INSURANCE						
LEGAL/ACCOUNTING/AUDIT						
PROFESSIONAL DUES						
OTHER (ATTACH ITEMIZATION)						
TOTAL DIRECT COSTS						
INDIRECT COST						
TOTAL COSTS						
LESS: CLIENT FEES						
DHMH FUNDING						

DHMH 432B (Rev. Feb. 1997)

PROGRAM BUDGET
ESTIMATED PERFORMANCE MEASURES

PROGRAM ADMINISTRATION: ________________ AWARD NUMBER: ________

FISCAL YEAR: ________ CONTRACT PERIOD: ________ SUBMITTED: ________

ORGANIZATION ________________ PHONE NUMBER: ________

ADDRESS: ________________ ZIP: ________

PROGRAM TITLE: ________________

PERFORMANCE MEASURE	BUDGET YEAR FY ________ ESTIMATE

DHMH 432C (Feb. 1997)

ORGANIZATION: ____________________

AWARD NUMBER: ____________________ FISCAL YEAR ____________________

FOR DHMH USE ONLY: ____________________

SCHEDULE OF SALARY COSTS

MERIT SYSTEM ____________

JOB TITLE OR CLASSIFICATION	NAME OF PERSON FILLING POSITION	GRADE AND STEP	HOURS PER WEEK	TYPE OF SERVICE	SALARY DHMH FUNDING	SALARY TOTAL PROGRAM BUDGET
TOTAL /MUST EQUAL 432B						

DHMH 432D (Rev. Feb. 1997)

ORGANIZATION: ____________________

AWARD NUMBER: ____________________ FISCAL YEAR ____________________

FOR DHMH USE ONLY: ____________________

SCHEDULE OF CONSULTANT COSTS

NAME OF CONSULTANT	PROFESSIONAL AREA	HIGHEST DEGREE HELD	HOURLY RATE	TOTAL HOURS	TOTAL DHMH COSTS	TOTAL PROGRAM BUDGET
TOTAL (MUST EQUAL 432B)						

DHMH 432E (Rev. Feb. 1997)

SCHEDULE OF EQUIPMENT COSTS

			DHMH FUNDING	TOTAL PROGRAM BUDGET
LIST OF MISCELLANEOUS EQUIPMENT COSTING UNDER $500 EACH				
LIST BELOW EACH EQUIPMENT ITEM COSTING OVER $500				
DESCRIPTION	CLIENT or OFFICE	NEW or REPLACEMENT		
TOTAL (MUST EQUAL 432B)				

DHMH432F (Rev. Feb. 1997)

PURCHASE OF SERVICE

SERVICE	VENDOR	PERFORMANCE MEASURES NUMBER UNITS PURCHASED (e.g., HRS, VISITS, ETC.)	DOLLARS	
			DHMH	TOTAL
TOTAL	XXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXX		

Total must equal 432B

DHMH432G (Feb. 1997)

ANTICIPATED SOURCES OF FUNDING

SOURCES	AMOUNT
DHMH AWARD	
DHMH SUPPLEMENT	
LOCAL GOV'T	
OTHER AWARD - FED, STATE OR PRIVATE AGENCY (SPECIFY)	
FEES	
DHMH CLIENT FEE COLLECTIONS	
OTHER CLIENT FEE COLLECTIONS	
MEDICAID PAYMENTS	
MEDICARE PAYMENTS	
INSURANCE/PRIVATE	
SSI	
OTHER - IDENTIFY	
FUNDRAISING/DONATIONS	
UNITED CHARITIES	
INTEREST	
Total Funding (Must Equal Total Costs in Total Program Budget on Budget Face Sheet	

IN-KIND CONTRIBUTIONS (IDENTIFY)	VALUE

TOTAL CASH PLUS IN-KIND	

DHMH432H (Rev. Feb.1997)