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**

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

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

9 5 **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 _____

LINE ITEMS MAY NOT BE CHANGED	DHMH FUNDING REQUEST	SUPPLEMENTAL FUNDING REDUCTION	OTHER DIRECT FUNDING FED./STATE LOCAL & GOV'T	OTHER DIRECT FUNDING ALL OTHER AGENCY	OTHER DIRECT FUNDING 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				

*****Total must equal 432B***

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)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HUMAN SERVICE AGREEMENT
REQUEST FOR PAYMENT - VENDOR INVOICE - DHMH 437 FORM

1) VENDOR NAME _____
2) VENDOR ADDRESS _____
3) CITY/STATE/ZIP _____
4) PROJECT TITLE _____
5) TELEPHONE NUMBER _____
6) DIRECTOR'S NAME _____
7) FEDERAL EMPLOYER ID _____

8) STATE FISCAL YEAR : _____
9) CONTRACT AWARD #: _____
10) REQUESTING PERIOD: _____ **TO** _____

By my signature, I attest that this information is correct, that the requested payment is just and correct and that payment for the same services/period have not been requested previously.

11) SIGNATURE _____ (Blue Ink) DATE _____

PART A. Award - Human Service Agreement

Amount of Human Services Award $ _____

Amount of CSA Administrative Award $ _____

PART B. Vendor's Request - Human Service Agreement

Amount of Human Services Award Request $ _____

Amount of CSA Administrative Request $ _____

Total Payment Request $ _____

PART C. DHMH SUBPROVIDER BUDGET REVIEW ATTESTATION (FOR DHMH USE ONLY)

We have reviewed and maintain on file, documentation of the DHMH subprovider budgets included in the purchase of service line item in the DHMH provider budget for this human service agreement or have a similar assurance by the vendor of record on file.

DHMH Funding Administration Representative _____ (Print Name) _____ (Signature)

Date _____

NOTE: *The above attestation is required before any invoice, after and including the October(quarterly) or November (bi-monthly) vendor invoice, can be paid by the Division of Program Cost and Analysis.*

PART D. DHMH PAYMENT (FOR DHMH USE ONLY)

Amount of Human Services Payment $ _____

Amount of CSA Administrative Payment $ _____

Total Approved Payment $ _____

Approved By _____

Date _____

Notes: _____