DEPARTMENT OF PUBLIC HEALTH

SERVICE DESCRIPTION	RESP. CENTER: MATERNAL AND CHILD HEALTH	DATE:

CONTRACTOR NAME: (List names if Unitary Contract)	CONTRACT TITLE

TYPE OF SERVICE (* Indicate if legally mandated)	RATE CHARGED	# OF CLIENTS SERVED	UNIT OF MEASUREMENT	# OF UNITS	COST PER UNIT OR CLIENT	

ADMINISTRATIVE/OVERHEAD COST:	ADMIN./OVERHEAD COST AS % OF TOTAL COST	AT (U

SPECIAL CONDITIONS	1. Describe specific program expectations:
. Specify Allocation Source (e.g. Title XX, Waiver, etc.):	
. Indicate in detail special conditions (i.e. insurance, auditing, etc.):	

4. Payment Type and Schedule **Describe**

_____ **Fee-for-Service. (Attach Fee Schedule)**
_____ **Program Funded**
_____ **Advances**
_____ **Invoices (Attach Billing Schedules)**
_____ **Other**

5. Other