

DEPARTMENT OF PUBLIC HEALTH

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|---|---------------------|---|----------------------------|-------------------|--------------------------------|------------------------|
| SERVICE DESCRIPTION | | RESP. CENTER: MATERNAL AND CHILD HEALTH | | | DATE: | |
| CONTRACTOR NAME: (List names if Unitary Contract) | | | CONTRACT TITLE | | | |
| TYPE OF SERVICE <small>(* Indicate if legally mandated)</small> | RATE CHARGED | # OF CLIENTS SERVED | UNIT OF MEASUREMENT | # OF UNITS | COST PER UNIT OR CLIENT | |
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| ADMINISTRATIVE/OVERHEAD COST: | | ADMIN./OVERHEAD COST AS % OF TOTAL COST | | | | A |
| SPECIAL CONDITIONS | | 1. Describe specific program expectations: | | | | (U |
| 2. Specify Allocation Source (e.g. Title XX, Waiver, etc.): | | | | | | |
| 3. Indicate in detail special conditions (i.e. insurance, auditing, etc.): | | | | | | |
| 4. Payment Type and Schedule | | | | | | <u>Describe</u> |
| Fee-for-Service. (Attach Fee Schedule) Program Funded Advances Invoices (Attach Billing Schedules) Other | | | | | | |
| 5. Other | | | | | | |