

PROGRAM BUDGET REQUEST FORM		FOR THE PERIOD OF
To: Department of Public Health, Maternal and Child Health		TOTAL MCH FUND APPROVED
AGENCY NAME		
STREET ADDRESS:		
CITY/STATE:	ZIP CODE:	
CONTRACT NUMBER:		
CONTRACT NAME:		
SECTION 1 – NON-MCH REVENUE AND INCOME FOR PROGRAM BUDGET		CERTIFICATION
DIRECT FEDERAL REVENUES:	\$ _____	I certify that I am the Facility of said organization, and the revenues for the period shown best of my knowledge and belief shown on these forms with the related balances of the and are in accordance with and directives as required Commonwealth, and City; understands that any and all are made in reliance by Mate the statement l
REVENUE FROM OTHER CITY AGENCIES:	\$ _____	
OTHER REVENUES (IDENTIFY):	\$ _____	
CLIENT FEES (IDENTIFY)	\$ _____	
PRIVATE HEALTH INSURANCE PAYMENTS:	\$ _____	
MEDICAL ASSISTANCE PAYMENTS:	\$ _____	
OTHER THIRD-PARTY PAYMENTS (IDENTIFY):	\$ _____	
OTHER INCOME (IDENTIFY):	\$ _____	
IN-KIND CONTRIBUTIONS:	\$ _____	
TOTAL SECTION 1:	\$ _____	
SECTION 2 – REQUEST FOR MCH REVENUE FOR PROGRAM BUDGET		Prepared by:
TOTAL PROGRAM COST:	\$ _____	Facility Director/Administrator (Signature)
(SECTION 3, PART A, COLUMN 4)		
LESS: NON-MCH REVENUES AND INCOME:	\$ _____	Approved: Director, Maternal & Child Heal
(SECTION 1, TOTAL)		
REQUEST FOR FUNDING TO MCH:	\$ _____	
THIS BUDGET MAY BE REVISED WITH THE WRITTEN APPROVAL OF THE DIRECTOR OF MATERNAL & CHILD HEA		

**INSTRUCTIONS – PROGRAM BUDGET REPORTING AND INVOICING FORM IN**

**Name:**

Name and address of the provider preparing the report. This name should be the same party as indicated in the contract with MCH.

**Contract Name and Contract Number:**

Identify the program for which the budget is being prepared and the City contract number. Obtain the City contract number from page 1 of the contract.

**For the period of:**

These dates represent the cumulative period for which the report is prepared, for example, where the contract begins on 7/1 the voucher submitted on 8/31 is for the period of 7/1 to 8/31.

**Total MCH Funds Approved:**

Indicate the amount of MCH funding approved as stipulated in the contract or the amount being requested if this is a budget being submitted for funding.

**Certification Statement:**

**Prepared by/Telephone Number:**

Indicate the name and phone number of the individual at the corporation who has prepared the budget report/invoice.

**Administrator or Executive Director:**

The individual who is contractually responsible to MCH must sign and date the budget report/invoice.

**Program Budget Request Form**

**Section I – Cumulative Revenue and Income Earned Applicable to Eligible Expenses:**

Indicate in this part all revenue and income of the program to be applied to the total eligible expenses shown on page 2, Section III, Contract Expenses for either the proposed budget.

**Cumulative Non-MCH Revenue and Income:**

In this section, the facility must report the cumulative amount of revenue and income earned from all sources of funding other than contractual payments from MCH. For more specific instructions as to the manner of reporting such revenue and income, please observe the following:

Revenue – Revenue is classified as funding which has been obligated to the service provider by a grant, contract, award letter or other documented agreement. Revenues are earned as a consequence of a formal funding commitment accomplished in advance of the work or services to be performed. Revenue commitments should include as an integral part identification as to purpose for which the funds are obligated.

Direct Federal – Revenue earned by the service provider directly from the Federal government for provision of services included in this program. The intent is to identify Federal dollars earned by the recipient to defray existing costs or expand service scope or capacity.

Revenue from other city Agencies – Revenue earned from a City agency other than MCH.

Other Revenue – Revenue earned from other government agencies.

Income – Income is classified as funding which is earned from operating. Income funds are not accompanied by a commitment) on the part of the payer. In the most common cases, income is received from payers as a reimbursement for services rendered to and donations (funding obtained without obligation income).

Client Fees – Income earned directly from liable clients.

Private Health Insurance – Income earned from insurance provided by employer and/or union health plans and private purchase.

Medical Assistance – Income earned from the Pennsylvania Department of Health for reimbursable medical services.

Other Third Party Fees – Income earned in the form of gifts (i.e., funds donated to the service provider as a general fund). The donor determines the purpose for which the funds will be used. Interest or other charges may be included.

In-Kind Contributions – Use this to indicate funding received in kind.

**Section II – Request for MCH Revenue for Program Revision:**

This section is to be used by the provider (1) when requesting a budget revision.

Total Program Cost: Indicate the total eligible expenses to be paid for the program obtained from the total of Section III, Column 2.

Less: Non-MCH Revenues and Income: Deduct the total of non-MCH revenues and income from the total line of Section I.

Request for Funding to MCH: This item is calculated as the difference between Total Program Cost and represents the actual amount of funding requested from MCH.

PROGRAM BUDGET REQUEST FORM		FOR THE PERIOD OF 7/1/97
To: Department of Public Health, Maternal and Child Health		TOTAL MCH FUND APPROVED
AGENCY NAME: ABC Agency		
STREET ADDRESS: 100 Main Street		
CITY/STATE: Phila, PA	ZIP CODE: 19000	
CONTRACT NUMBER: Budget		
CONTRACT NAME: MCH Education		

SECTION 1 – NON-MCH REVENUE AND INCOME FOR PROGRAM BUDGET

DIRECT FEDERAL REVENUES:	\$ _____
REVENUE FROM OTHER CITY AGENCIES:	\$ _____
OTHER REVENUES (IDENTIFY):	\$ _____
PRIVATE HEALTH INSURANCE PAYMENTS:	\$ _____
MEDICAL ASSISTANCE PAYMENTS:	\$ _____
OTHER THIRD-PARTY PAYMENTS (IDENTIFY):	\$ _____
OTHER INCOME (IDENTIFY):	\$ _____
IN-KIND CONTRIBUTIONS:	\$ _____
TOTAL SECTION 1:	\$ _____

**CERTIFICATION**

I certify that I am the Facility of said organization, and the revenues for the period shown best of my knowledge and belief are shown on these forms with the related balances of the accounts and are in accordance with the laws, regulations, and directives as required by the Commonwealth, and City; I understand that any and all actions taken are made in reliance by Maternal and Child Health on the statement of the Facility Director/Administrator.

SECTION 2 – REQUEST FOR MCH REVENUE FOR PROGRAM BUDGET

TOTAL PROGRAM COST:	\$ 90,000 _____
(SECTION 3, PART A, COLUMN 4)	
LESS: NON-MCH REVENUES AND INCOME:	\$ -- _____
(SECTION 1, TOTAL)	
REQUEST FOR FUNDING TO MCH:	\$ 90,000 _____

Prepared by: \_\_\_\_\_

Facility Director/Administrator (Signature)

Approved: Director, Maternal & Child Health

THIS BUDGET MAY BE REVISED WITH THE WRITTEN APPROVAL OF THE DIRECTOR OF MATERNAL & CHILD HEALTH

MATERNAL AND CHILD HEALTH 500 SOUTH BROAD STREET PHILADELPHIA, PA 19146			
SECTION III – CONTRACT EXPENSES	CURRENT CONTRACT	CONTRACT BUDGET	OTHER PROGRAM

BUDGET CATEGORIES	BUDGET FY 96 (COLUMN 1)	FY 97 (COLUMN 2)	FUNDS FY 97 (COLUMN 3)	(SUM OI
<b>PERSONNEL SERVICES (100)</b>				
121-CLIENT ORIENTED SERVICE	55,600	58,749		
SALARIES	11,676	11,456		
122-CLIENT ORIENTED SERVICE BENEFITS				
123-STAFF DEVELOPMENT				
<b>SUB-TOTAL PERSONNEL SERVICES</b>	67,276	70,205		
<b>OPERATING EXPENSES (300)</b>				
301-BOARD EXPENSES				
302-CONSULTANT EXP				
311-RENTS	4,271	4,718		
312-UTILITIES				
313-INSURANCE	2,224	2,636		
314-HOUSEKEEPING				
321-COMMUNICATION	1,131	691		
331-OFFICE SUPPLIES	1,000	517		
341-MEDICAL SUPPLIES				
342-DRUGS				
343-FOOD AND CLOTHING				
344-REHABILITATION SUPPLIES	3,000	1,000		
351-STAFF TRAVEL	960	1,452		
352-CLIENT TRANSPORT				
361-PURCHASED PHYSICIAN				
362-PURCHASED CLIENT ORIENTED SERVICES				
362-PURCHASED CLIENT ORIENTED SERVICES				
383-OTHER OPERATING EXPENSES	10,138	8,781		
<b>SUB-TOTAL OPERATING EXPENSES</b>	22,724	19,795		
<b>FIXED ASSETS (400)</b>				
401-CLIENT EQUIPMENT AND FURNISHING				
402-CLIENT SERVICES EQUIPMENT				
<b>SUBTOTAL FIXED ASSETS</b>				
<b>TOTAL</b>	90,000	90,000		

MATERNAL AND CHILD HEALTH  
500 SOUTH BROAD STREET  
PHILADELPHIA, PA 19146

SECTION III – CONTRACT EXPENSES	TOTAL CONTRACT BUDGET FY 97	FIRST QUARTER BUDGET	SECOND QUARTER BUDGET	
BUDGET CATEGORIES				
<b>PERSONNEL SERVICES</b>				
111-ADMINISTRATIVE SALARIES				
121-CLIENT ORIENTED SERVICE SALARIES	58,749	14,687	14,687	
122-CLIENT ORIENTED SERVICE BENEFITS	11,456	2,864	2,864	
123-STAFF DEVELOPMENT				
<b>SUBTOTAL: PERSONNEL SERVICES</b>	70,205	17,551	17,551	
<b>OPERATING EXPENSES (300)</b>				
301-BOARD EXPENSES				
302-CONSULTANT EXPENSES				
311-RENTS	4,718	1,180	1,180	
312-UTILITIES				
313-INSURANCE	2,636	659	659	
321-COMMUNICATION	691	173	173	
331-OFFICE SUPPLIES	517	129	129	
341-MEDICAL SUPPLIES				
344-REHABILITATION SUPPLIES	1,000	250	250	
351-STAFF TRAVEL	1,452	363	363	
352-CLIENT TRANSPORT				
383-OTHER OPERATING EXPENSES	8,781	2,195	2,195	
SUBTOTAL OPERATING EXPENSES	19,975	4,949	4,949	
<b>FIXED ASSETS (400)</b>				
401-OFFICE EQUIPMENT & FURNISHINGS				
402-CLIENT SERVICES EQUIPMENT				
410-CAPITAL LEASES				
SUBTOTAL FIXED ASSETS				
<b>TOTAL</b>	90,000	22,500	22,500	



## INSTRUCTIONS – PERSONNEL ROSTER

**AGENCY CORPORATE NAME:**

ENTER AGENCY'S CORPORATE NAME AS IT APPEARS ON THE CORRESPONDING CONTRACT.

**CONTRACT NUMBER AND CONTRACT NAME:**

ENTER THE CORRESPONDING CONTRACT NUMBER AND CONTRACT NAME.

**CUMULATIVE REPORTING PERIOD:**

ENTER THE CUMULATIVE REPORTING PERIOD WHICH AGREES WITH THE COM  
CORRESPONDING CONTRACT.

**HOURS PER WEEK:**

ENTER THE TOTAL HOURS PER WEEK THAT THE EMPLOYEE IS EMPLOYED BY THE AGENCY.

**ANNUAL RATE:**

ENTER THE APPROVED ANNUAL SALARY THE EMPLOYEE RECEIVES FROM THE AGENCY REGARDLESS OF  
MATERNAL AND INFANT HEALTH.

**CUMULATIVE AMOUNT PAID:**

ENTER THE TOTAL AMOUNT THE EMPLOYEE HAS BEEN PAID BILLABLE TO MATERNAL AND INFANT HEA  
OF THE CONTRACT. (FOR BUDGET PREPARATION PURPOSES, THIS IS THE TOTAL SALARY COST TO BE E  
PERIOD).

**SALARY BREAKDOWN BY ACTIVITY BY DOLLARS OF % OF TIME:**

IF AN EMPLOYEE'S SALARY IS BEING CHARGED TO MORE THAN ONE FUNDED ACTIVITY, INDICATE THE %  
CHARGED TO MATERNAL AND INFANT HEALTH FOR EACH ACTIVITY. DISTINGUISH BETWEEN ACTIVITIES

**EMPLOYEE TERMINATION DATE:**

IF AN EMPLOYEE CHARGED TO THE CONTRACT TERMINATES EMPLOYMENT DURING THE CONTRACT PE  
TO BE REFLECTED. THE EMPLOYEE AND ALL INFORMATION PREVIOUSLY PROVIDED SHOULD CONTINUE  
SUBSEQUENT REPORTS WITH THE TERMINATION DATE. IF A REPLACEMENT FOR THE TERMINATED EMP  
REPLACEMENT EMPLOYEE SHOULD BE LISTED ON THE PERSONNEL ROSTER AFTER THE TERMINATED EMP

