Cecile Erwin Young, Executive Commissioner

Request for Applications (RFA)
for
2-1-1 Texas Information and Referral Network Operations
RFA No. HHS0009792

Exhibit H-2 - Expenditure Proposal Instructions and Examples
All fields of Exhibit H, Expenditure Proposal Template must be completed.
For instances of no cost, Applicants may enter $0.00.

***Applicants are required to submit a separate Expenditure Proposal for each AIC, per Region, and for Emergency Services and Escalation Centers, if applicable.***

**ADMINISTRATIVE COSTS INSTRUCTIONS**

If your HHSC contract agreement requires a cap on administrative costs, each budget category will include a column for tracking the administrative costs. For each line item, include how much of the costs for that line item are "administrative" costs. This column will not auto-populate as other total columns do.

NOTE: Only contracts requiring an administrative costs cap will include a column for tracking "Administrative Costs".

Administrative costs typically include things such as administrative positions (CEO, CFO, administrative assistants); costs, such as utilities and rent which are allocated to these positions; and indirect costs; however, the definition of "administrative costs" may be unique to your program, so please contact your contract manager if you are unsure what should be included as administrative costs.

## BUDGET SUMMARY INSTRUCTIONS

You should budget for all costs your organization will incur or request reimbursement for while implementing the program per HHSC contract agreement.

1. **Legal Name of Contractor:** Enter your organization's legal name.
2. **Address**: Enter your organization's address, city, state, and zip code
3. **Tax ID Number:** Enter your State of Texas issued Texas Identification Number (TIN)

***Budget Summary Cost Category Amounts will prepopulate from each cost category page.*

## Budget Summary

| | | |
|---|---|---|
| **Legal Name:** | | ABC Service Provider |

| | |
|---|---|
| **Address 1:** | 123 Main St. |
| **Address 2:** | Suite 1 |
| **City, State, Zip:** | Austin, TX 77777 |
| **Tax ID Number:** | 1712345678 |

| TOTAL | | |
|---|---|---|
| **Cost Categories** | | **Total Budget Requested** |
| A. Personnel | | $0 |
| B. Fringe Benefits | | $0 |
| C. Travel | | $0 |
| D. Equipment | | $0 |
| E. Supplies | | $0 |
| F. Contractual | | $0 |
| G. Other | | $0 |
| H. Total Direct Costs: | | $0 |
| I. Indirect Costs | | $0 |
| **J. Total (Sum of H and I)** | | **$0** |

## Personnel & Fringe Instructions

## FRINGE BENEFITS

Fringe benefits are provided by the organization as compensation to its employees. Fringe benefits include, but are not limited to, the cost of employee insurance, pensions, and unemployment benefit plans. The cost of fringe benefits is allowable (in proportion to the amount of time or effort employees devote to the grant funded project), to the extent that the benefits are reasonable and are in accordance with 2 CFR Part 200.

**INSTRUCTIONS:**

**Fringe Benefits:** Provide a detailed list of costs that comprise your organizations fringe benefits.

**Fringe Benefits Rate**: The fringe benefit rate should be based on your organization's actual expenditures. The fringe benefit rate is typically calculated by dividing your organizations total fringe benefit costs by total wage/salary costs. Enter your organizations fringe benefit rate on the Personnel budget tab.

**Fringe Benefits Total:** The total fringe benefit amount will be automatically calculated by multiplying the rate times the salary total.

## PERSONNEL

The actual cost of employee salaries devoted to working on activities directly related to the HHSC funded program. These costs are allowable to the extent that they are identified in the contract budget and conform to 2 CFR Part 200.

**INSTRUCTIONS:**

**Staff Position:** Enter the functional title; multiple positions with the same title must be listed separately.

**Certification/License Required:** Any certification or license an individual must possess to be qualified for the position.

**Vacant V/F:** Indicate whether the position is vacant (V) or filled (F).

**Justification:** Enter a brief description for each position and how it supports the program(s), identify part time staff with "PT".

**Monthly Salary:** Enter the total monthly salary of employees for this functional title.

**Number of Months:** Enter the number of months this position will support the program during this fiscal year.

**Annual Salary:** This column will automatically calculate the annual salary of each line item based on the monthly salary times number of months.

## Personnel & Fringe

**Legal Name:** 0

**FRINGE BENEFITS** **Describe the Fringe Benefits allocated to the program(s):**

For example: Federal Income Contributions Act (FICA) 7.65%, State Unemployment Tax Account (SUTA) 2.35%. FICA includes Medicare and Social Security amounts combined.

| | |
|---|---|
| **Fringe Benefit Rate %** | 10.00% |
| **Fringe Benefits Total (auto-populates)** | $8,280 |

***Total amounts auto-populate***

**PERSONNEL**

| Staff Position | Certification or License (Enter NA if not required) | Vacant V/F | Justification | Monthly Salary | No. of Months | Total Annual Salary |
|---|---|---|---|---|---|---|
| I&R Specialist | NA | F | Conducts I&R services 1 FTE | $2,600.00 | 12 | $31,200 |
| Case Manager | NA | F | Provides case management and referrals to clients. | $2,500.00 | 12 | $30,000 |
| Administrative assistant | N/A | F | Assists with report completion; answers phone calls, greets walk-ins | $1,800.00 | 12 | $21,600 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | **Total Salary** | **$82,800** |

## TRAVEL Instructions

The cost of transportation, lodging, meals, and related expenses incurred by employees of the organization while performing duties relevant to the program(s). Costs related to conference registration fees should be classified under the "Other" cost category.

**ALL OUT OF STATE TRAVEL MUST HAVE HHSC PRIOR APPROVAL AT LEAST 30-DAYS IN ADVANCE OF TRAVEL. INCLUSION IN AN APPROVED BUDGET DOES NOT CONSTITUTE APPROVAL FOR OUT OF STATE TRAVEL.**

All contracts with HHSC require a written travel policy maintained by the contractor and available for review by HHSC staff upon request. HHSC will only reimburse travel costs up to the maximum travel rates as identified in

**<u>Conferences/Trainings/Statewide Meetings Instructions:</u>** The TRAVEL tab requires information on travel costs associated with your HHSC Program.

**Description of conference/trainings/statewide meetings:** Include the name and description of the conference/trainings/statewide meetings.

**Justification:** Briefly explain how the conference/training/statewide meeting is applicable to your program. Travel dates MUST BE included in the justification.

**Location:** Identify the location of conference/training/statewide meeting.

**Number of Days/Employees:** Identify the number of days and employees attending the conference/training/statewide meeting.

**Travel Total Costs**: For each conference/training/statewide meeting, enter the total cost for mileage, airfare, meals, lodging, and other costs. If Other costs are included, a description of the costs must be included in the justification. The Travel Total Cost columns will be automatically populated by summing the amounts entered

**<u>For other/local travel costs</u>**:

**Justification:** Briefly explain how the other/local travel is applicable to your program. Regular travel trips to the same locations may be included in one line item, but the justification must explain the frequency and destination for the trips.

**Number of Miles:** Enter the total mileage for the trip, to include round trip mileage between headquarters and the destination.

**Mileage Reimbursement Rate:** Enter the organizational mileage reimbursement rate, rates cannot be higher than the approved state rate.

**Mileage Cost:** The total will be automatically populated by multiplying the number of miles entered by the reimbursement rate entered.

**Other Costs:** Enter the total for other costs, such as rental cars, gas purchased for rental cares, tolls, parking

## Travel

**Legal Name:** 0

**ALL OUT OF STATE TRAVEL MUST HAVE HHSC PRIOR APPROVAL AT LEAST 30-DAYS IN ADVANCE OF TRAVEL. INCLUSION IN AN APPROVED BUDGET DOES NOT CONSTITUTE APPROVAL FO**

***Total amounts auto-populate***

**Conference/Workshop Travel**

| Description of Conference/Workshop | Justification | Location City/State | Number of: Days/Employees | Travel Costs | | Total: Travel Total Costs |
|---|---|---|---|---|---|---|
| Dallas Conference | Attending Annual Program Conference to discuss program adjustments and goals | Dallas, Texas | 3/2 | Mileage | $800 | |
| | | | | Airfare | $900 | |
| | | | | Meals | $0 | |
| | | | | Lodging | $0 | |
| | | | | Other Costs | $0 | $1,700 |
| Client Needs Symposium | The program director will attend this symposium, which will provide sessions on identifying community and client needs, developing action and case plans to address these needs, and how to track success when working with clients. The director will incur expenses for taxi service to and from the hotel. | Little Rock, Arkansas | 3/1 | Mileage | $100 | |
| | | | | Airfare | $450 | |
| | | | | Meals | $177 | |
| | | | | Lodging | $288 | |
| | | | | Other Costs | $21 | $1,036 |
| | | | | Mileage | $0 | |
| | | | | Airfare | $0 | |
| | | | | Meals | $0 | |
| | | | | Lodging | $0 | |
| | | | | Other Costs | $0 | $0 |
| | | | | Mileage | $0 | |
| | | | | Airfare | $0 | |
| | | | | Meals | $0 | |
| | | | | Lodging | $0 | |
| | | | | Other Costs | $0 | $0 |
| | | | | **Total** | | **$2,736** |

**Other / Local Travel Costs**

| Justification | Number of Miles | Mileage Reimbursement Rate (cannot exceed maximum state rate) | Mileage Cost (a) (auto-populates) | Other Costs (b) | Total (a) + (b) (auto-populates) |
|---|---|---|---|---|---|
| Case manager will visit all outlying counties at least once per month. Will incur nominal parking fees and tolls. | 2400 | $0.535 | $1,284 | $200 | $1,484 |
| Director will attend regular workgroups and advisory committees throughout the service area. Nominal parking and toll fees will be incurred. | 600 | $0.535 | $321 | $35 | $356 |
| | | | $0 | | $0 |
| | | | $0 | | $0 |
| | | | | Total for Other / Local Travel | $1,840 |

**Other / Local Travel Costs:** $1,840

**Conference / Workshop Travel Costs:** $2,736

**Total Travel Costs:** **$4,576**

Revised: 7/6/2009

SUPPLIES Instructions

Supplies are defined as consumable items necessary to carry out the services under this HHSC program including office supplies, patient educational supplies, software, and any items of tangible items other than those defined under equipment.

The Comptroller of Texas includes the following items as controlled assets. These items require pre-approval for purchase. **CONTROLLED ASSETS REQUIRE PRIOR APPROVAL. INCLUSION IN AN APPROVED BUDGET DOES NOT CONSTITUTE APPROVAL.**
(https://fmx.cpa.texas.gov/fmx/pubs/spaproc/appendices/appa/appa_6.php)

Any Cost Items: Hand guns, rifles, and shotguns
Include if item costs $500-$4,999.99: Sound systems and other audio equipment, camera (portable, digital, SLR), TVs, video players/recorders, computers (laptops and desktops), data projectors, smartphones, and tablets and other hand held devices.

**INSTRUCTIONS**::
**Description of Item:** Describe each supply item.

**Purpose & Justification:** State the purpose for the item(s) and why the item is necessary to support the program.

**Total Cost:** Enter the total cost of the requested item(s).

## Supplies

**Legal Name:** 0

| Description of Item | Purpose & Justification | Total Cost |
|---|---|---|
| General office supplies | Program staff will need general office supplies, such as pens, notepads, post-it notes, staples, etc., to conduct day to day business. Amount is based on historical data from previous fiscal years. | $950 |
| | | $0 |
| | | $0 |
| | **Total Supplies:** | **$950** |

## EQUIPMENT Instructions

**Equipment**

2 CFR Part 200 - §200.33 Equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or $5,000.

See also 2 CFR Part 200 - §200.12 Capital assets, §200.20 Computing devices, §200.48 General purpose equipment, §200.58 Information technology systems, §200.89 Special purpose equipment, and §200.94 Supplies.
Electronic Code of Federal REgulations can be found here. (https://www.ecfr.gov/cgi-bin/text-idx?SID=948b06c8a2fe4098a61bee7f81f4f220&node=2:1.1.2.2.1&rgn=div5#se2.1.200_133)

**INSTRUCTIONS:**

**Description of Item:** Describe each line item of equipment and attach a complete specification, if available.

**Purpose & Justification:** State the purpose for the item(s) and why the equipment is necessary. Also, if a portion of the equipment cost is funded by non-HHSC funds, name the funding source and include the percentage of the cost being funded in the "Indirect Cost" tab.

**Number of Units:** Enter the number of units (quantity) to be purchased.

**Cost Per Unit:** Enter the cost per unit.

**Total:** The total will automatically calculate by multiplying the cost by the number of units.

# Equipment

**Legal Name:** 0

| Description of Item | Purpose & Justification | Number of Units | Cost Per Unit | Total |
|---|---|---|---|---|
| Laptop computer | The case manager's current computer is 10 years old and has crashed repeatedly. | 1 | $1,200 | $1,200 |
| | | | | $0 |
| | | | | $0 |
| | | | | $0 |
| | | | **Total Equipment:** | **$1,200** |

Revised: 7/6/2009

## UNITS/RATES Instructions

The costs of activities directly associated with carrying out the statement of work that directly applies to the total rate and number of units to provide serivces for a client.

**INSTRUCTIONS**

**Personnel:** Identify the staff portion of time directly related to performing the service. For example: 10% of the CEO's time is dedicated to this contract. The CEO makes $85,000 per year including fringe and the hourly cost is $41.43. Therefore the rate is $41.43 X 4 hours per week for a total cost of $165.69.

**Travel:** Identify the portion of staff travel cost directly related to perfroming the service.

**Professional/Contract Name:** Identify the individual organizations performing the service. List the unit rate and total units for services provied.

**Method of Payment**: Identify the method of payment as monthly, hourly, unit, and/or lump sum.

**# of Months, Hours, Units, etc.:** Enter the number of months, hours, units, etc. of service to be purchased.

**Rate of Payment:** Identify the hourly rate, unit rate, and/or lump sum amount.

## Professional/Contract

**Legal Name: 0**

**UNTS AND RATES**

| Unit/Rate Components | Method of Payment (i.e., Monthly, Hourly, Unit, Lump Sum) | # of Months, Hours, Units, etc per client. | Rate of Payment (i.e., hourly rate, unit rate, lump sum amount) | TOTAL |
|---|---|---|---|---|
| Personnel | 1 hour = 1 unit | 40 | $32.00 | $1,280 |
| Travel | 20% Cost per Trip = 1 unit | 10 | $350.00 | $3,500 |
| Supples | 10% of Cost = 1 unit | 2,500 | $17.00 | $42,500 |
| Professional/Contract Services (List each seperately) | 1 hour = 1 unit | 24,000 | $10.00 | $240,000 |
| Professional/Contract Services (List each seperately) | 1 day = 1 unit | 365 | $36.00 | $13,140 |
| Professional/Contract Services (List each seperately) | 1 month = 1 unit | 12 | $120.00 | $1,440 |
| | | | | $0 |
| | | | | $0 |
| | | | **Total Professional/Contract:** | **$301,860** |

Revised: 7/6/2009

**PROFESSIONAL/SUBCONTRACTOR Instructions**

The costs of activities directly associated with carrying out the statement of work that are contracted by the organization to a third party are recoded in the Professional/Subcontractor category. The Respondent may enter into contracts with subrecipient subcontractors unless restricted or otherwise prohibited in the HHSC contract. Prior to entering into an agreement equaling $100,000 or more, the Contractor shall obtain written approval from HHSC.

**A subcontractor agreement shall be in writing and include the following:**

- Name and address of all parties;
- A detailed description of the services to be provided;
- Measurable method and rate of payment and total amount of contract;
- Clearly defined and executable termination clause;
- Terms of Service dates;
- Access to inspect subcontracted service activities in the premises on which services are performed, in accordance with the General Provisions.

Attach a copy of the General Provisions, Statement of Work, and any Special Provisions applicable to the subcontract.

Contractor is responsible to HHSC for the performance of any subcontractor. Contractor shall monitor both financial and programmatic performance and maintain pertinent records that shall be available for inspection by HHSC. Contractor shall ensure that subcontractors are fully aware of the requirements placed upon them by state/federal statutes and regulations and under this Contract. Contractor shall not contract with a subcontractor, at any tier, which is debarred or suspended or excluded from or ineligible for participation in federal assistance programs. When subcontracting, Contractor is required to meet all applicable HUB requirements.

**INSTRUCTIONS**

**Professional/Contract Name:** Identify the individual organizations performing the service.

**Description of Service:** Enter a description of the services being contracted.

**Justification:** Enter a justification describing why the HHSC contractor needs to contract for the service, why the service is necessary to perform the scope of work, and how the HHSC contractor will ensure that the cost of the service is reasonable.

**Method of Payment**: Identify the method of payment as monthly, hourly, unit, and/or lump sum.

**# of Months, Hours, Units, etc.:** Enter the number of months, hours, units, etc. of service to be purchased.

**Rate of Payment:** Identify the hourly rate, unit rate, and/or lump sum amount.

**Total:** The total will be automatically populated by multiplying the number of months, units, etc. by the rate of payment.

## Professional/Subcontractor

**Legal Name:** 0

| Professional / Contract Name | Description of Services | Justification | Method of Payment (i.e., Monthly, Hourly, Unit, Lump Sum) | # of Months, Hours, Units, etc. | Rate of Payment (i.e., hourly rate, unit rate, lump sum amount) | TOTAL |
|---|---|---|---|---|---|---|
| Attendant Services | Will provide attendant care to clients meeting eligibility requirements within Travis and Bastrop Counties. | Attendant care is a requirement of the contract. | 1 hour = 1 unit | 24,000 | $17.00 | $408,000 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | **Total Professional/Contract:** | **$408,000** |

## OTHER Instructions

All other direct costs not listed in any other cost category are to be included in "Other". Examples of these costs include: non-contractual fees and travel paid directly to individual consultants; local transportation, which means all travel which does not require per diem; space rentals; utility and telephone expenses; printing and publication costs; training costs, including tuition and stipends; training service costs, including wage payments to individuals and supportive service payments; and staff development costs.

**INSTRUCTIONS:**

**Description of Item:** Enter a general description of the good(s)/service(s), include quantity if applicable.

**Purpose & Justification:** Enter an explanation of the purpose of the good(s)/service(s) and why it is necessary for the program.

**Total Cost:** The total cost should only include the cost of good(s)/service(s) which will be consumed during the contract term and services that will be utilized during the contract term.

## Other

**Legal Name:** 0

| **Description of Item**<br>[If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)] | **Purpose & Justification** | **Total Cost** |
|---|---|---|
| Office space rent, 250 sq. ft. | The program staff each maintain office space and costs are allocated based on square footage. Each square foot costs $20 annually. | $5,000 |
| | | $0 |
| | | $0 |
| | **Total Other:** | **$5,000** |

## INDIRECT COST Instructions

If using an approved indirect cost rate, the Contractor must submit an indirect cost rate letter from a cognizant agency.

Regardless of the indirect cost rate method, the Contractor must submit a cost allocation plan specifically identifying all costs included in the indirect cost rate, and those which will be paid directly.

**INSTRUCTIONS**

**Approved rate:** Enter the indirect cost rate to be used during the fiscal year. This rate must be supported by an approved indirect cost rate letter, central service cost allocation plan, or be no more than the 10% de minimis rate allowable per Title 2 CFR 200.

**Indirect Cost Method Used:** From the drop down box, select the method of determining the indirect cost rate. Supporting documentation for all methods must be provided with the completed budget.

**Effective Date:** Enter the date the indirect cost rate became effective.

**Expiration Date:** Enter the date the indirect cost rate expires.

**Modified Total Direct Cost or Other Cost Base:** Enter the total amount of the contract expenses against which an indirect cost rate will apply. For instance, if the approved indirect cost rate may only be applied to salaries, enter the total amount of salaries to be charged indirect costs. Modified total direct costs should exclude costs over $25,000 for any individual subcontractor. See 2 CFR 200.68 for more information.

**Central Service Cost Allocation Plan**: Governmental entities choosing to use a central service cost allocation plan should complete this section with a brief description of the costs which are included in the rate.

**De minimis and approved indirect cost rates**: Organizations utilizing the de minimis rate or an approved rate should identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base.

Identify the most recent Indirect Cost rate (if applicable). This is either an approved indirect cost rate, Central Service Cost Allocation Plan, or the De Minimis Rate in accordance with 2 CFR Part 200. **Submit a copy of the cost rate certificate with this budget.**

| | |
|---|---|
| **Estimated or Approved Rate:** | 20.00% |

| Indirect Cost Method Used | Effective Date | Expiration Date | Modified Total Direct Cost or Other Cost Base | Maximum Indirect Cost Amount |
|---|---|---|---|---|
| Central Service Cost Allocation Plan | 5/16/2016 | 9/31/2019 | $45,660.00 | $9,132.00 |

**Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**

Expenses included in the indirect cost rate are salaries, fringe benefits and operational costs relating to general administration (GA) staff. GA staff includes the executive director, CFO, and Finance department (purchasing, payroll, accounts receivable, and accounts payable). Operating costs include office supplies, postage, copier usage, phone, and utilities. Operating costs are allocated based on square footage for utilities and usage rates for office supplies, postage, copies, and phone.