TEXAS
Health and Human Services

Cecile Erwin Young, Executive Commissioner

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

Exhibit H, Expenditure Proposal Template

Funding Opportunity:	Area Information Center (AIC Only)
Region:	Select the Region

Applicants must complete one Exhibit H, Expenditure Proposal Template, for each Region.

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.				

2-1-1 Texas Information and Referral Network Operations

Budget Summary

Legal Name:	

Address 1:	
Address 2:	
City, State, Zip:	
Tax ID Number:	

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

Personnel

Legal Name: 0

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

Fringe Benefit Rate %	
Fringe Benefits Total (auto-populates)	$0

Total amounts auto-populate

PERSONNEL						**Total**
Staff Position	**Certification or License (Enter NA if not required)**	**Vacant V/F**	**Justification**	**Monthly Salary**	**No. of Months**	**Annual Salary**
						$0
						$0
						$0
						$0
						$0
						$0
						$0
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						$0
						$0
						$0
					Total Salary	$0

Revised: 7/6/2009

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 FOR OUT OF STATE TRAVEL.

Do you have a travel policy more restrictive than what is allowed by the contract? Yes/No

Total amounts auto-populate

Conference/Workshop Travel

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Total: Travel Costs		Total: Travel Total Costs
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				Mileage	$0	
				Airfare	$0	
				Meals	$0	
				Lodging	$0	
				Other Costs	$0	$0
				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		**$0**

Other / Local Travel Costs

Total amounts auto-populate

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)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
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			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0	Total for Other / Local Travel	$0

Other / Local Travel Costs:	$0	**Conference / Workshop Travel Costs:**	$0	**Total Travel Costs:**	**$0**

Equipment

Legal Name: **0**

ALL EQUIPMENT MUST HAVE HHSC PRIOR APPROVAL. INCLUSION IN AN APPROVED BUDGET DOES NOT CONSTITUTE APPROVAL.

Total amounts auto-populate

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
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				$0
				$0
				$0
	Total Equipment:			**$0**

Supplies

Legal Name: 0

Total amounts auto-populate

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
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		$0
		$0
		$0
		$0
		$0
		$0
		$0
	Total Supplies:	**$0**

Professional/Contract

Legal Name: 0

Total amounts auto-populate

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
						$0
						$0
						$0
						$0
						$0
						$0
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						$0
						$0
					Total Professional/Contract:	**$0**

Other

Legal Name: **0**

***Total amounts auto-populate**

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	**Purpose & Justification**	**Total Cost**
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
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		$0

Total Other:	**$0**

Indirect Costs

Legal Name: **0**

Enter the total amount of indirect costs, if any. If no indirect costs are requested, enter "none."

The Respondent may request indirect costs if it has a current indirect cost rate agreement. A Respondent without an Indirect Cost Rate Letter can use at a rate less than a 10% rate until such letter is provided to HHSCof the direct charges. **Submit a copy of the cost rate certificate with this budget.**

Approved Rate:	10.00%

Indirect Cost Method Used	Effective Date	Expiration Date	Modified Total Direct Cost or Other Cost Base	Maximum Indirect Cost Amount
				$0.00

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