

*Michigan Department
of Community Health*



Jennifer M. Granholm, Governor
Janet Olszewski, Director

REQUEST FOR PROPOSAL

for

Dental Preventive Services in State-Funded Child and Adolescent Health Centers

Issued by:

Michigan Department of Community health
Oral Health Program
109 Michigan Ave., Fourth Floor
Lansing, Michigan 48933
Phone: (517) 335-9526
FAX: (517) 335-8697

Notification of Intent to Apply Due: January 29, 2010
Proposals Due: March 15, 2010

Copies Required: Signed Original plus 3 copies

- One in four Michigan 3rd grade children (25.0%) have untreated dental disease. Hispanic and African American schoolchildren had higher rates of untreated dental disease. Lower socioeconomic status and lack of dental insurance were also associated with untreated dental disease.
- Michigan 3rd grade children who attended schools in optimally fluoridated communities had significantly fewer teeth affected by caries (cavities) than children who attended schools in communities that lack optimally fluoridated community water supplies.

Access to Oral Health Services:

- Lack of dental insurance poses a significant barrier to obtaining dental care for children. Nearly one in six 3rd grade children (15.1%) lack dental insurance – twice the number of Michigan children who lack medical insurance. Uninsured children had significantly more dental disease and substantially less access to dental services.
- Roughly one in nine Michigan 3rd grade children (11.2%) encountered problems that prevented them from obtaining dental care in the past year. Increased difficulty in obtaining dental care was common among all racial and ethnic minorities as well as children not covered by private dental insurance. Cost and a lack of dental insurance were the two most frequently cited reasons for failure to obtain dental care.
- A substantial number of children visit the dentist every year with 84.4% of parents reporting that their child had visited the dentist in the past year. A lack of dental insurance was strongly associated with failing to visit the dentist, particularly among Hispanics.
- Despite the high rate of dental service utilization, only 23.3% of 3rd grade children in Michigan had sealants present on first molar teeth, far below the Healthy People 2010 goal of 50%. Hispanic children were much less likely to have sealants present with only 14.6% having sealants present.

Regional Information:

- Upper Peninsula and Northern Lower Peninsula children had the highest rates of caries experience and untreated decay. However, evidence suggests that expansion of community water fluoridation could significantly reduce the number of teeth that have been affected by caries in the region.
- The rural Southern Lower Peninsula had the lowest rates of sealant placement and the highest proportion of uninsured children. In addition, free and reduced lunch children encountered significantly more dental disease.
- The urban Southern Lower Peninsula had the highest rates of immediate dental needs with 17.4% of children showing signs or symptoms of pain, swelling, or infection. The disease burden was substantially higher for African American and Hispanic children in this region.
- Children who attend school in Wayne County experience dental disease at higher rates compared to children who attend school in either Macomb or Oakland County. Significant social and racial disparities exist in both dental disease and access all across the Detroit Metropolitan area.

PURPOSE:

To address the high decay rate of children in areas of greatest disparity, the Michigan Department of Community Health (MDCH), Oral Health Program, is offering a grant created specifically for State-Funded Child and Adolescent Health Centers to support the development of a school-based

dental preventive services program with links to comprehensive dental services (fillings, examinations, etc.).

The program is to achieve two goals:

1. Establish a dental sealant program for 2nd grade children with erupted first permanent molars and 6th grade children with erupted second permanent molars.
2. Ensure restorative treatment of active dental disease discovered through the dental sealant program.

Programs that improve access to oral health services for children with special health care needs will be given priority. New programs have priority for funding; however, agencies previously funded through this grant may apply.

Strategies to achieve the goals include:

1. Projects may utilize a PA 161 hygienist (a hygienist who performs preventative oral health services without direct dental supervision) for establishment of a dental sealant program. A direct referral mechanism must be in place for comprehensive dental health services through a Memorandum of Understanding, contract or similar agreement with a FQHC, public health clinic, community clinic or other dental provider that demonstrates commitment to provide dental restorative services to children referred by the dental sealant program.
2. A Memorandum of Understanding, contract or similar agreement with a FQHC, public health clinic, community clinic or other dental provider that demonstrates commitment to provide a dental sealant program and ensure dental restorative treatment for children identified as requiring services by the dental sealant program.

ELIGIBLE APPLICANTS

Child and Adolescent Health Centers that serve elementary grades.

Interested parties should submit via e-mail or fax a Notice of Intent to Apply for Funding Form 1 (NOIAF) no later than 5:00 P.M. on January 29, 2010. Application is due by March 15, 2010, at 5:00 pm. **Applicants should be notified of award decisions by April 15, 2010.** Any funds received by the Contractor but not spent for the specific purposes of the project must be returned to MDCH. In submitting the application, the applicant assures that funds will only be used for the intended project purpose.

AVAILABILITY OF FUNDING

Funding is made possible for this grant through *HRSA-H47-09-002 Targeted Oral Health Service System Grant Project*. One award will be made for \$80,000. Billing of services through third party payers such as Medicaid, Blue Cross/Blue Shield, Delta Dental and other dental insurance companies is expected.

A local match of 30% is required for this application. The 30% match may be in-kind support: contributions of staff time, space for the dental mobile equipment, supplies, volunteer time, and other resources. Federal funds cannot be used as a match.

PROJECT PERIOD

Awards will be based on a one-year funding cycle from October 1, 2010 – August 31, 2011 based on availability of funds. Full sustainability of the project is expected after the grant is expended.

CONTRACTOR RESPONSIBILITIES

The contractor will be required to assume responsibility for all contractual activities offered in the proposal whether or not that contractor performs them. If any part of the work is to be subcontracted, responses to this RFP must include a list of subcontractors including the firm name and address, the name of the contact person, a complete description of the work to be subcontracted, and information concerning the subcontractor's organizational abilities. The state will consider the selected contractor to be the sole point of contact with regard to project matters, including payment of any and all charges resulting from the award.

REIMBURSEMENT MECHANISM

All contractors must sign-up through the on-line vendor registration process to receive all State of Michigan payments as Electronic Funds Transfers (EFT) / Direct Deposits, as mandated by PA 533 of 2004. Vendor registration information is available through the Department of Management and Budget web site: <http://www.cpexpress.state.mi.us/> Reimbursement may be through grant agreement, Purchase Order (PO) or other process dependent on the state process. A DCH 0665 is attached for your information.

DISCLOSURE OF PROPOSAL CONTENTS

All information in an applicant's proposal is subject to disclosure under the provisions of Public Act No. 442 of 1976, known as the "Freedom of Information Act." This act also provides for the disclosure of contracts and attachments thereto.

ISSUING OFFICE

This RFP is issued by the Michigan Department of Community Health, Oral Health Program. The issuing office is the sole point of contact for persons/organizations who are considering preparing a response to this RFP. The award is contingent upon the availability of funds and administrative approval. MDCH reserves the right to terminate any contract due to failure to meet established minimum program and reporting requirements and/or failure to meet annual negotiated performance numbers.

USE OF FUNDS

Funds available under this announcement must be focused on costs for implementing a school-based dental preventive services program with links to comprehensive dental services (fillings, etc.). Any funds received by the recipient of the award but not spent for the specific purpose must be returned to the Michigan Department of Community Health (MDCH). In submitting the application, the applicant assures that funds will only be used for the intended grant purpose. The MDCH will not assume any responsibility or liability for costs incurred by the recipient of the award prior to the signing of an agreement.

Requests for proposals MAY include the following expenses:

1. Professional staff compensation, including costs for coordination, clinical services and collection
2. Transportation expenses for staff and volunteers
3. Portable or stationary dental equipment up to \$18,000
4. Clinical supplies and instruments
5. Dental sealant and fluoride varnish material

Funds MAY NOT be used for:

1. Endowment funds
2. Computer software
3. Volunteer gifts
4. DIAGNODENT or similar caries detection device

USE OF PRIVATE INSURANCE

Recipients of the grant must make reasonable efforts to collect third party fees, where applicable, and report these as outlined by the Department's fiscal procedures. First party fees from those receiving the sealants are limited to donations only. All eligible participants without insurance or Medicaid will be offered the service free of charge. Third party payors are dental health insurers such as Blue Cross/Blue Shield and Delta Dental. Any under recoveries of otherwise available fees resulting from failure to bill for eligible services will be excluded from reimbursable expenditures.

WHERE TO OBTAIN ASSISTANCE

Questions regarding proposals should be directed to Dr. Sheila Vandebush, Oral Health Director, via e-mail at oralhealth@michigan.gov. Include GRANT ASSISTANCE in the subject line.

SPECIFICATIONS

All proposals must address or comply with the following specifications:

1. Provide application of sealants to second grade children with erupted first permanent molars and sixth grade children with erupted second permanent molars in the selected school(s) who return a positive parent permission slip, regardless of ability to pay. Children without dental insurance must receive free sealants through this program.
2. Ensure restorative treatment of active dental disease identified through the dental sealant program. Projects must demonstrate facilitation of access to comprehensive dental care through a Memorandum of Understanding, contract or similar agreement with a FQHC, public health clinic, community clinic or other dental provider that demonstrates commitment to provide emergency dental restorative services to children referred by the dental sealant program. The dental services should be available with a 20 mile radius of the school.
3. Clinical requirements include the utilization of a mobile dental chair, light, handpiece, and suction or a fixed dental unit. Dental instrument sterilization equipment must be available. Sufficient space must be located for utilization and safe storage of the equipment.
4. Medicaid and third party payers must be billed, when applicable.

5. Programs that improve access to oral health services for children with special health care needs will be given priority.
6. Programs must use CDC SEALS software for data collection for dental sealants. The program must have at least one individual attend a SEALS software training. Training and SEALS software are free to the grantee, however, travel to attend training in Lansing should be included in the budget.

Program Monitoring

- a) Indicate how you will track information to improve your project's performance
- b) Internal management mechanisms that will be utilized to track whether or not planned project activities are carried out to include the number of children screened, number of dental sealants placed, number of children referred, number of children receiving comprehensive dental services, number of positive permission slips, etc.

Quality assurance:

- a) Detail how a sealant retention check on 20% of children will be managed and how sealant retention rates of 90% or better on occlusal surfaces and 65% or better in buccal and lingual grooves will be maintained.
- b) Projects must adhere to professional standards as outlined in the State of Michigan Administrative Dental Rules:
http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=33811101&Dpt=CH&RngHigh=
- c) Projects must adhere to OSHA and MIOSHA standards as well as to CDC guidelines on infection control and hand washing. <http://www.cdc.gov/ncidod/dhgp/guidelines.html> Projects must provide experienced and competent staff to accomplish program goals including a description of how the project will be staffed and the responsibilities of staff and volunteers.
- d) Projects must be conducted within the State of Michigan.

Required Reporting

- a) Projects Grantee must submit a Financial Status Report (FSR) no later than thirty (30) days after the close of each calendar month to the Michigan Department of Community Health (MDCH), Bureau of Finance AND the MDCH Oral Health Program. The final agreement FSR is due thirty (30) days after the end of the agreement.
- b) Grantee must complete an interim report by March 1, 2011, and a final report by August 31, 2011, that includes the following:
 - o Progress done on the work plan (progress made toward achievement of the measurable milestones and outcome objectives stated in the work plan)
 - o Experience to date (summary of the extent to which the activities were completed, number of dental sealants placed, number of children referred, number of children receiving comprehensive dental services, number of positive permission slips, etc.)
 - o How the grant improved the oral health status of the following populations:
 - Oral health services for children with special health care needs
 - Ensured restorative treatment of active disease through the sealant program
 - o Significant changes since the start of the project (key personnel, contracts, financial resources, etc.)

- Collaboration – Existing and planned methods of collaboration and coordination with other relevant agencies, organizations, providers, etc.
- Monitoring – Indicate how you tracked information to improve your project's performance, internal management mechanisms utilized to track whether or not planned project activities were actually carried out, quality assurance of dental care.
- Significant Results – Summarize significant results to date, such as improvements to or expansions of the project-related activities, collaborations, etc., and discuss how these findings have implications for your project and/or has potential impact on school or community policies/practices.
- Final Report – A final SEALS software report is due August 31, 2011.

DIRECTIONS FOR COMPLETING THE GRANT APPLICATION

I. Cover Sheet *(see page 14)*

A. Name of School Center/Applicant: _____

B. Amount of Request: \$ _____

C. Name of Applicant Organization: Enter in the name of the applicant or organization. Enter the name and title of the person officially authorized by the applicant organization to enter into agreements, (usually chief administrative officer). Enter the mailing address, including city, county, state and ZIP code. Enter the telephone number, fax number and e-mail address.

D. Contact Person: Enter the name and title of the contact person who will be responsible for overseeing the project. Enter the mailing address, including city, county, state and ZIP code. Enter the telephone number, fax number and e-mail address.

E. Legal Status of Organization: *(check only one response)* – check the box that applies. Attach copy of requested IRS materials.

F. Federal Tax ID Number – Enter Federal Tax ID number (may also be known as Federal Employer Identification Number [FEIN] as assigned by IRS.

G. Authorizing Entity – An official authorized to bind the applicant Organization to its provisions must sign the original proposal in ink. Print name and enter date of signature.

II. Proposal

A. Complete Form 1 and submit prior to May 15 , 2009 (Notice of Intent to Apply for Funding Form (NOIAF)

B. Budget Summary and Program Budget Cost Detail Schedule—Using the Budget Completion instructions included in the RFP (see Attachment B), please complete both budget forms (see Attachment B1: DCH-0385 (Budget Summary) and DCH-0386 (Program Budget Cost Detail Schedule).

III. Narrative Guidelines

A. Font: Please use an easily readable serif typeface, such as Times Roman, Courier, Helvetica, Arial or CG Times. The text portion of the application must be submitted in not less than 12 point and 1.0 line spacing. For charts, graphs, footnotes and budget tables, applicants may use a different pitch or size font, not less than 10 pitch or size font. However, it is vital that when scanned and/or reproduced, the charts are still clear and readable.

B. Paper Size and Margins: The application must be printed on 8½" x 11" white paper. Margins must be at least one (1) inch at the top, bottom, left and right of the paper. Please left-align text.

C. Page Numbering: Please number all pages, beginning with the title or cover page as page 1.

D. Page Limit: Page limit is 10 pages; the Title Page or Cover Sheet, Forms, Budget, MOU, Contract and/or Agreement from a FQHC, public health clinic, community clinic, dental school, or other dental provider that demonstrates commitment to provide emergency

dental restorative services for children are not included in the page limit. The Work Plan is not included in the page limit.

SELECTION CRITERIA

Applications for grants will be reviewed by a committee established by the MDCH. Applications will be scored on the following criteria:

A. Needs Assessment (10 points):

Provide information about the health and oral health needs of children within the geographic region of the Child and Adolescent Health Center. Include data on existing health or oral health programs, barriers to health that children in the school face, short anecdotal stories of service delivery problems, etc.

B. Grantee affiliation and Organizational Capacity (10 points):

Applicants should list past collaborative efforts in the delivery of dental or medical health services, length of the relationships, and existing referral networks for dental services. The Memorandum of Understanding, contract, or similar agreement with a FQHC, public health clinic, community clinic, dental school, or other dental provider that demonstrates commitment to provide dental restorative services for children referred through the dental sealant program should support the organizational capacity described.

D. Grant Narrative (25 points): The narrative should address how the following will be accomplished:

1. Implement a dental sealant program that:
 - a) Provides assessment and recording of existing conditions prior to placement of the dental sealants.
 - b) Provide application of sealants to 1st, 2nd, and 3rd grade children with erupted first permanent molars and 6th grade children with erupted second permanent molars in the selected school(s) who return a positive parent permission slip, regardless of ability to pay. Children without dental insurance must receive free sealants through this program.
 - c) At least one oral health education session for each school for the target population prior to sealant placement.
 - d) Addresses how education of parents/guardians of the value of sealants in the prevention of dental disease will be used to encourage positive permission for sealant placement
2. Ensure restorative treatment of active dental disease identified through the dental sealant program. Projects must demonstrate facilitation of access to comprehensive dental care. A Memorandum of Understanding, contract or similar agreement with a FQHC, public health clinic, community clinic or other dental provider must be attached that demonstrates commitment to provide dental restorative services to children referred by the dental sealant program. The dental services should be available with a 20 mile radius of the school.
3. Clinical requirements include the utilization of a mobile dental chair, light, handpiece, and suction or a fixed dental unit. Dental instrument sterilization equipment must be available. Sufficient space must be located for utilization and safe storage of the equipment.

4. Medicaid and third party payers will be billed, when applicable.
5. Programs should address how access to oral health services for children with special health care needs will be provided.
6. Program Monitoring
 - a) Indicate how you will track information to improve your project's performance
 - b) Internal management mechanisms that will be utilized to track whether or not planned project activities are carried out to include the number of children screened, the number of dental sealants placed, number of children referred, number of children receiving comprehensive dental services, number of positive permission slips, etc
7. Quality assurance:
 - a) Projects must perform a sealant retention check on 20% of children and maintain sealant retention rates of 90% or better on occlusal surfaces and 65% or better in buccal and lingual grooves.
 - b) Projects must adhere to professional standards as outlined in the State of Michigan Administrative Dental Rules:

http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=33811101&Dpt=CH&RngHigh=

- c) Projects must adhere to OSHA and MIOSHA standards as well as to CDC guidelines on infection control and hand washing. <http://www.cdc.gov/ncidod/dhqp/guidelines.html>
 - i. Projects must provide experienced and competent staff to accomplish program goals including a description of how the project will be staffed and the responsibilities of staff and volunteers.
 - ii. Projects must be conducted within the State of Michigan.

E. Work Plan (10 points): The work plan must include goals and objectives, a time line, and person(s) responsible. The work plan should include all points listed in "D" above. Utilize the template provided as Form 2.

F. Project Sustainability (5 points): The proposal must demonstrate the capacity to sustain services beyond the one year funding cycle. In-kind contributions of staff time and other resources are expected both from the applicant and from project partners.

Form 1
Notice of Intent to Apply for Funding
Dental Preventive Services in State-Funded Child and Adolescent Health Centers
Due January 29, 2010, at 5:00 P.M.

Funding Period: October 1, 2010 – August 31, 2011

Name of School Center/Applicant: _____

Federal Tax Identification Number: _____

County: _____

Contact Person: _____

Title: _____

Mailing Address: _____

City: _____ Michigan ZIP: _____

County: _____ E-mail: _____

Phone: () _____ Fax: () _____

Authorized Individual (*signature*)

Printed Name

Date

Fax (517) 335-8697 or e-mail to oralhealth@michigan.gov. If e-mailing, please place GRANT in the subject line.

Form 2
Dental Preventive Services in State-Funded Child and Adolescent Health Centers Work Plan
(please print or type)

Please use additional pages if needed

Goals	SMART Objectives Specific Measurable Attainable Realistic Time Measured	Time Line	Person Responsible

APPLICATION COVER SHEET

Dental Preventive Services in State-Funded Child and Adolescent Health Centers
Application Due: March 15, 2010
(please print or type)

A. Project Title: _____

B. Total Amount of Request: \$ _____

C. Name of School Center/Applicant: _____

Authorized Official: _____

Title: _____

Mailing Address: _____

City: _____ Michigan ZIP: _____

County: _____ E-mail: _____

Phone: () _____ Fax: () _____

D. Authorized Official: _____

Title: _____

Mailing Address: _____

City: _____ Michigan ZIP: _____

County: _____ E-mail: _____

Phone: () _____ Fax: () _____

E. Legal Status of Organization (check only one response)

Non-Profit Entity (attach copy of IRS's 501 c (3) or other legal documentation verifying status)

Public Agency/Unit of a governmental

Other: _____

F. Federal Tax ID/Federal Employer Identification (FEIN) Number: _____

G. Authorizing Entity: I hereby affirm my authority and responsibility for the use of all equipment and/or educational training described in this application.

Authorized Individual (*signature*)

Printed Name

Date

ATTACHMENT B-2

PROGRAM BUDGET – COST DETAIL SCHEDULE

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

*View at 100% or Larger
Use WHOLE DOLLARS Only*

Page Of

PROGRAM		BUDGET PERIOD		DATE PREPARED	
		From:	To:		
CONTRACTOR NAME		BUDGET AGREEMENT		AMENDMENT #	
		<input type="checkbox"/> ORIGINAL	<input type="checkbox"/> AMENDMENT		
SALARY & WAGES	POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY	
				\$0	
				\$0	
				\$0	
				\$0	
				\$0	
				\$0	
				\$0	
1. TOTAL SALARIES & WAGES:			0	\$ 0	
2. FRINGE BENEFITS (Specify) <input type="checkbox"/> FICA <input type="checkbox"/> LIFE INS. <input type="checkbox"/> DENTAL INS. COMPOSITE RATE <input type="checkbox"/> UNEMPLOY INS. <input type="checkbox"/> VISION INS. <input type="checkbox"/> WORK COMP. AMOUNT 0.00% <input type="checkbox"/> RETIREMENT <input type="checkbox"/> HEARING INS. <input type="checkbox"/> HOSPITAL INS. <input type="checkbox"/> OTHER (specify) _____				2. TOTAL FRINGE BENEFITS:	\$0
3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)					
3 TOTAL TRAVEL:				\$0	
4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)					
4. TOTAL SUPPLIES & MATERIALS:				\$0	
5. CONTRACTUAL (Specify Subcontracts/Subrecipients)					
<u>Name</u>	<u>Address</u>	<u>Amount</u>			
5. TOTAL CONTRACTUAL:				\$0	
6. EQUIPMENT (Specify items)					
6. TOTAL EQUIPMENT:				\$0	
7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)					
7. TOTAL OTHER:				\$0	
8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)		8. TOTAL DIRECT EXPENDITURES:		\$ 0	
9. INDIRECT COST CALCULATIONS		Rate #1: Base \$0 X Rate 0.0000 % Total		\$ 0	
		Rate #2: Base \$0 X Rate 0.0000 % Total		\$ 0	
9. TOTAL INDIRECT EXPENDITURES:				\$ 0	
10. TOTAL EXPENDITURES (Sum of lines 8-9)				\$ 0	
AUTHORITY: P.A. 368 of 1978 COMPLETION: Is Voluntary, but is required as a condition of funding		The Department of Community Health is an equal opportunity employer, services and programs provider.			
DCH-0386 (E) (Rev 05-08) (W) Previous Edition Obsolete. Use Additional Sheets as Needed					

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)**I. INTRODUCTION**

The budget should reflect all expenditures and funding sources associated with the program, including fees and collections and local, state and federal funding sources. When developing a budget it is important to note that total expenditures for a program must equal total funds.

The Program Budget Summary (DCH-0385) is utilized to provide a standard format for the presentation of the financial requirements (both expenditure and funding) for each applicable program. Detail information supporting the Program Budget Summary is contained in the Program Budget-Cost Detail Schedule (DCH-0386). General instruction for the completion of these forms follows in Sections II-III. Budgets must be submitted on Michigan Department of Community Health approved forms.

II. PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION

Use the **Program Budget Summary (DCH-0385)** supplied by the Michigan Department of Community Health. An example of this form is attached (**see Attachment B.1**) for reference. **The DCH-0386 form should be completed prior to completing the DCH-0385 form.** (Please note: the excel workbook version of the DCH 0385-0386 automatically updates the Program Summary amounts as the user completes the DCH-0386).

- A. Program - Enter the title of the program.
- B. Date Prepared - Enter the date prepared.
- C. Page ___ of ___ - Enter the page number of this page and the total number of pages comprising the complete budget package.
- D. Contractor Name - Enter the name of the Contractor.
- E. Budget Period - Enter the inclusive dates of the budget period.
- F. Mailing Address - Enter the complete address of the Contractor.
- G. Budget Agreement: Original or Amended - Check whether this is an original budget or an amended budget. The budget attached to the agreement at the time it is signed is considered the original budget although it may have been revised in the negotiation process. If the budget pertains to an amendment, enter the amendment number to which the budget is attached.
- H. Federal Identification Number – Enter the Employer Identification Number (EIN), also known as a Federal Tax Identification Number.

Expenditure Category Column – All expenditure amounts for the DCH-0385 form should be obtained from the total amounts computed on the Program Budget - Cost Detail Schedule (DCH-0386). (See Section III for explanation of expenditure categories.)

Expenditures:

1. Salaries Salary and Wages
2. Fringe Benefits
3. Travel
4. Supplies and Materials
5. Contractual (Subcontracts/Subrecipients)
6. Equipment
7. Other Expenses
8. Total Direct Expenditures

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

9. Indirect Costs
10. Total Expenditures
- J. Source of Funds – Refers to the various funding sources that are used to support the program. Funds used to support the program should be recorded in this section according to the following categories:
 11. Fees and Collections - Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.
 12. State Agreement - Enter the amount of MDCH funding allocated for support of this program. This amount includes all state and federal funds received by the Department that are to be awarded to the Contractor through the agreement.
 13. Local - Enter the amount of Contractor funds utilized for support of this program. In-kind and donated services from other agencies/sources should not be included on this line.
 14. Federal - Enter the amount of any Federal grants received directly by the Contractor in support of this program and identify the type of grant received in the space provided.
 15. Other(s) - Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by MDCH.
16. Total Funding - The total funding amount is entered on line 16. This amount is determined by adding lines 11 through 15. The total funding amount must be equal to line 10 - Total Expenditures.
- K. Total Budget Column - The Program Budget Summary is designed for use in presenting a budget for a specific program agreement funded in part by or through the Department or some other non-local funding source. Total Budget column represents the program budget amount. **The “K” Total Budget column must be completed while the remaining columns are not required unless additional detail is required by the Department.**

III. PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION

Use the **Program Budget-Cost Detail Schedule (DCH-0386)** supplied by the Michigan Department of Community Health. An example of this form is attached (**see Attachment B.2**) for reference. Use additional pages if needed.

- A. Page ____ of ____ - Enter the page number of this page and the total number of pages comprising the complete budget package.
- B. Program - Enter the title of the program.
- C. Budget Period - Enter the inclusive dates of the budget period.
- D. Date Prepared - Enter the date prepared.
- E. Contractor Name - Enter the name of the contractor.

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

- F. Budget Agreement: Original or Amended - Check whether this is an original budget or an amended budget. If an amended budget, enter the amendment number to which the budget is attached.

Expenditure Categories:

- G. Salaries Salary and Wages - Position Description - List all position titles or job descriptions required to staff the program. This category includes compensation paid to all permanent and part-time employees on the payroll of the contractor and assigned directly to the program. This category does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, professional fees or personnel hired on a private contracting basis should be included in Other Expenses. Contracts with subrecipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Subcontracts/Subrecipients) Expenses.
- H. Comments - Enter any explanatory information to clarify the position description or the calculation of the positions salary and wages or fringe benefits, (i.e., if the employee is limited term and/or does not receive fringe benefits). that is necessary for the position description. Include an explanation of the computation of Total Salary in those instances when the computation is not straightforward (i.e., if the employee is limited term and/or does not receive fringe benefits).
- I. Positions Required - Enter the number of positions required for the program corresponding to the specific position title or description. This entry could be expressed as a decimal (e.g., Full-time equivalent – FTE) when necessary. If other than a full-time position is budgeted, it is necessary to have a basis in terms of a time study or time reports to support time charged to the program.
- J. Total Salary - Compute and enter the total salary cost by multiplying the number of positions required by the annual salary.
- K. Salaries Salary and Wages Total - Enter a total in the Positions Required column and the Total Salaries Salary and Wages column. The total salary and wages amount is transferred to the Program Budget Summary - Salaries Salary and Wages expenditure category. If more than one page is required, a subtotal should be entered on the last line of each page. On the last page, enter the total Salaries and Wages amounts attach an additional DCH 0386.
- L. Fringe Benefits – Check applicable fringe benefits for staff employees assigned to working in this program. This category includes the employer's contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees. Enter composite fringe benefit rate and total amount of fringe benefit. (The composite rate is calculated by dividing the fringe benefit amount by the salaries Salary and Wwages amount.)
- M. Travel - Enter cost of employee travel (mileage, lodging, registration fees). **Use only for travel costs of permanent and part-time employees assigned to the program.** This includes cost for mileage, per diem, lodging, lease vehicles, registration fees and approved seminars or conferences and other approved travel costs incurred by the employees (as listed under the Salaries Salary and Wages category) for conducting the program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Travel category (line 3) exceeds 10% of the Total Expenditures (line 10).** Travel of consultants is reported under Other Expenses - Consultant Services as part of the Consultant Services.
- N. Supplies & Materials - Enter cost of supplies & materials. This category is used for all consumable and short-term items and equipment items costing less than five thousand dollars (\$5,000). This includes office supplies, computers, office furniture, printers,

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

printing, janitorial, postage, educational supplies, medical supplies, contraceptives and vaccines, tape and gauze, education films, etc., according to the requirements of each applicable program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Supplies and Materials category (line 4) exceeds 10% of the Total Expenditures (line 10).**

- O. **Contractual (Subcontracts/Subrecipients) – Specify the subcontractor(s) working on this program in the space provided under line 5.** Specific details **must** include: 1) subcontractor(s) and/or subrecipient(s) name and address, 2) amount by for each subcontractor and/or subrecipient, 3) the total amount for all subcontractor(s) and/or subrecipient(s). Multiple small subcontracts can be grouped (e.g., various worksite subcontracts). Use this category for written contracts or agreements with subrecipient organizations such as affiliates, cooperating institutions or delegate contractors when compliance with federal grant requirements is delegated (passed-through) to the subrecipient contractor. Vendor payments such as stipends and allowances for trainees, fee-for-service or fixed-unit rate patient care, consulting fees, etc., are to be identified in the Other Expense category.
- P. **Equipment** - Enter a description of the equipment being purchased, (including number of units and the unit value), the total by type of equipment and total of all equipment. This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, installation costs and any taxes. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of \$5,000 or more per unit. **Equipment items costing less than five thousand dollars (\$5,000) each are to be included in the Supplies and Materials category. All equipment items summarized on this line must include: item description, quantity and budgeted amount and should be individually identified in the space provided under (line 6). Upon completing equipment purchase, equipment must be tagged and listed on the Equipment Inventory Schedule (see Attachment B.3) and submitted to the agreement’s contract manager.**
- Q. **Other Expenses** - This category includes other allowable cost incurred for the benefit of the program. The most significant items should be specifically specified. listed on the Cost Detail Schedule. Other mMinor items may be identified by general type of cost and summarized as a single line item on the Cost Detail Schedule to arrive at a total Other Expenses category. Some of the more sSignificant groups or subcategories of costs are described as follows and should be individually identified in the space provided on and under (line 7). **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Other Expenses category (line 7) exceeds 10% of the Total Expenditures (line 10).**
1. **Communication Costs** - Costs of telephone, telegraph, data lines, Internet access, websites, fax, email, etc., when related directly to the operation of the program.
 2. **Space Costs** - Costs of building space, rental and maintenance of equipment, instruments, etc., necessary for the operation of the program. If space is publicly owned, the cost may not exceed the rental of comparable space in privately owned facilities in the same general locality. **Department funds may not be used to purchase a building or land.**
 3. **Consultant or Vendor Services** - These are costs for consultation services, professional fees and personnel hired on a private contracting basis related to the planning and operations of the program, or for some special aspect of the project. Travel and other costs of these consultants are also to be included in this category.

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

4. Other - All other items purchased exclusively for the operation of the program and not previously included, such as patient care, fee for service, auto and building insurance, automobile and building maintenance, membership dues, fees, etc.
- R. Total Direct Expenditures – Enter the sum of items 1 – 7 on line 8.
- S. Indirect Costs Calculations - **Enter the allowable indirect costs for the budget.** Enter the base amount. Indirect costs can only be applied if an approved indirect costs rate has been established or an actual rate has been approved by a State of Michigan department (i.e., Michigan Department of Education) or the applicable federal cognizant agency and is accepted by the Department. Attach a current copy of the letter stating the applicable indirect costs rate. **Detail on how the indirect costs was calculated must be shown on the Cost Detail Schedule (DCH-0386).**
- T. Total Expenditures - Enter the sum of items 8 and 9 on line 10.

ATTACHMENT B.1

PROGRAM BUDGET SUMMARY
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

*View at 100% or Larger
Use WHOLE DOLLARS Only*

PROGRAM (A) Budget and Contracts			DATE PREPARED (B) 7/01/xx		Page (C) 1 1	Of 2
CONTRACTOR NAME (D) Michigan Agency			BUDGET PERIOD (E) From: 10/01/xx To: 9/30/xx			
MAILING ADDRESS (Number and Street) (F) 123 ABC Drive			(G) BUDGET AGREEMENT ORIGINAL AMENDMENT ►			AMENDMENT # 1
CITY Acme	STATE MI	ZIP CODE 44444	FEDERAL ID NUMBER (H) 38-1234567			
(I) EXPENDITURE CATEGORY						(K) TOTAL BUDGET (Use Whole Dollars)
1. SALARIES SALARY & WAGES			43,000			43,000
2. FRINGE BENEFITS			11,180			11,180
3. TRAVEL			1,400			1,400
4. SUPPLIES & MATERIALS			37,000			37,000
5. CONTRACTUAL (Subcontracts/Subrecipients)			3,500			3,500
6. EQUIPMENT			5,000			5,000
7. OTHER EXPENSES						
			8,000			8,000
9. TOTAL DIRECT EXPENDITURES (Sum of Lines 1-7)			110,090			110,090
9. INDIRECT COSTS: Rate #1 %						
INDIRECT COSTS: Rate #2 %						
10. TOTAL EXPENDITURES			110,090			110,090

EXAMPLE

(J) SOURCE OF FUNDS						
11. FEES & COLLECTIONS			10,000			10,000
12. STATE AGREEMENT			90,000			90,000
13. LOCAL			9,090			9,090
14. FEDERAL						
15. OTHER(S)						
16. TOTAL FUNDING			110,090			110,090

AUTHORITY: P.A. 368 of 1978 COMPLETION: Is Voluntary, but is required as a condition of funding	The Department of Community Health is an equal opportunity employer, services and programs provider.
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ATTACHMENT B. 2

PROGRAM BUDGET – COST DETAIL SCHEDULE

(A) Page 2 Of 2

View at 100% or Larger

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Use **WHOLE DOLLARS ONLY**

(B) PROGRAM		(C) BUDGET PERIOD		(D) DATE PREPARED
		From:	To:	
Budget and Contracts		10/01/xx	9/30/xx	7/01/xx
(E) CONTRACTOR NAME Michigan Agency		(F) BUDGET AGREEMENT ORIGINAL AMENDMENT		AMENDMENT #
(G)	(H) COMMENTS	(I) POSITIONS REQUIRED	(J) TOTAL SALARY	
1. SALARY & WAGES				
POSITION DESCRIPTION				
Nurse	9 month position	1	25,000	
Project Director		.5	18,000	
(K) 1. TOTAL SALARIES SALARY & WAGES:		1.5	\$ 43,000	
(L) 2. FRINGE BENEFITS (Specify)				
FICA	LIFE INS.	DENTAL INS	COMPOSITE RATE	
UNEMPLOY INS.	VISION INS.	WORK COMP	AMOUNT 26%	
RETIREMENT	HEARING INS.			
HOSPITAL INS.	OTHER (specify) _____			
2. TOTAL FRINGE BENEFITS:			\$ 11,180	
(M) 3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)				
Conference registration	\$350			
Airfare	\$600			
Hotel accommodations and per diem for 4 days	\$450			
			3 TOTAL TRAVEL:	
			\$ 1,400	

EXAMPLE

ATTACHMENT B. 2

(N) 4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)		
Office Supplies	2,000	
Medical supplies	35,000	
4. TOTAL SUPPLIES & MATERIALS:		\$ 37,000
(O) 5. CONTRACTUAL (Specify Subcontracts/Subrecipients)		
Subcontractor Name	Address	Amount
ACME Evaluation Services	555 Walnut, Lansing, MI 48933	\$ 2,000
Subrecipient Name		
Health Care Partners	333 Kalamazoo, Lansing, MI 48933	\$ 1,500
5. TOTAL CONTRACTUAL:		\$ 3,500
(P) 6. EQUIPMENT (Specify items)		
Microscope	\$5,000	
6. TOTAL EQUIPMENT:		\$ 5,000
(Q) 7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)		
Communication Costs	\$2,400	
Space Costs	\$3,600	
Consultant or Vendor: John Doe, Evaluator, 100 Main, E. Lansing	\$2,000	
7. TOTAL OTHER:		\$ 8,000
(R) 8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)		\$ 110,090
EXPENDITURES:		
(S) 9. INDIRECT COSTS CALCULATIONS		\$ 0
% Total	Rate #1: Base \$0 X Rate 0.0000	\$ 0
	Rate #2: Base \$0 X Rate 0.0000 %	\$ 0
Total		\$ 0
9. TOTAL INDIRECT EXPENDITURES:		
(T) 10. TOTAL EXPENDITURES (Sum of lines 8-9)		\$ 110,090
AUTHORITY: P.A. 368 of 1978		The Department of Community Health is an equal opportunity employer, services and programs provider.
COMPLETION: Is Voluntary, but is required as a condition of funding		
DCH-0385 (E) (Rev 52-076) (W) Previous Edition Obsolete. Use Additional Sheets as Needed		

ATTACHMENT B. 3
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CONTRACT MANAGEMENT SECTION

EQUIPMENT INVENTORY SCHEDULE

Please list equipment items that were purchased during the grant agreement period as specified in the grant agreement budget, Attachment B.2. Provide as much information about each piece as possible, including quantity, item name, item specifications: *make, model*, etc. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of \$5,000 or more per unit. Please complete and forward to this form to the MDCH contract manager with the final progress report.

Contractor Name: Michigan Agency Contract #: 200700020108000 Date: 10/31/0697

Quantity	Item Name	Item Specification	Tag Number	Purchase Price
1	<i>LW Scientific M5 Labscope</i>	<ul style="list-style-type: none"> • Binocular • Trinocular with C-mount or eye tube • 35mm and digital camera adapters available • Diopter adjustment • Inclined 30 degrees (45 degrees available), rotates 360 degrees • 10X/20 high point eyepieces • Interpupillary distance range 50-75mm 	N1038438EW109	\$ 5,000
				\$
				\$
				\$
				\$
				\$
				\$
Total				\$ 5,000

Contractor's Signature: _____ Date: _____