

*Michigan Department
of Community Health*



**Jennifer M. Granholm, Governor
Janet Olszewski, Director**

REQUEST FOR PROPOSAL

for

Primary and Preventive Dental Health Care Services Grant

Issued by:

Michigan Department of Community Health
Oral Health Program
109 West Michigan Avenue, Fourth Floor
Lansing, Michigan 48913
Phone: (517-335-8388)
Fax: (517-335-8294)

**Notification of Intent to Apply Due: September 21, 2007
Proposals Due: October 12, 2007**

Copies Required: Signed Original plus 3 copies

Instructions for Completing the Primary and Preventive Dental Health Care Services Grant Application

The Abbreviated Primary and Preventive Dental Health Services Grant Application was created specifically for public and non-profit eligible organizations to reduce health barriers and health disparities in Michigan through the establishment of oral health services in dental health professional shortage areas and provide community-based dental prevention programs. Projects will be funded through two separate requests for proposals addressing increased dental access and implementation of evidence-based dental health promotion/disease prevention programs. Only 1 grant will be funded from each category (Grant 1 and Grant 2).

Grant 1: Applicants may submit only one Abbreviated Application to increase dental access through the development or expansion of a community-based dental clinic. Requests must not exceed \$67,200

Grant 2: Applicants may submit only one Abbreviated Application to promote oral health through community-based dental health prevention activities. Requests must not exceed \$44,000.

Applicants should be located within a community-based clinic that offers a full range of healthcare services to populations bearing a disproportionate share of disease and disabilities.

All terms, conditions and limitations specified in the abbreviated grant application will be reviewed and scored according to relevant review criteria described in Selection Criteria on page five.

INSTRUCTIONS:

Applicants should review all included materials and selection criteria.

Notice of Intent to Apply must be completed on the form attached and submitted no later than September 21, 2007 at 5:00 p.m.

Applications that are not typed will be returned. **Completed applications, including one original and three (3) copies, are due no later than 5:00 p.m., October 12, 2007 to:**

Michigan Department of Community Health
Oral Health Program
Attn: Sheila Semler, Ph.D., Oral Health Director
109 West Michigan Avenue, Fourth Floor
Lansing, Michigan 48913
Phone: (517-335-8388)
Fax: (517-335-8294)

Applicants are responsible for the timely receipt of their proposal. **PROPOSALS RECEIVED AFTER THIS DATE AND TIME WILL NOT BE CONSIDERED. E-MAIL OR FAX RESPONSES WILL NOT BE ACCEPTED.**

BACKGROUND AND PURPOSE

The Michigan Department of Community Health (MDCH) Oral Health Program is offering a grant to reduce health barriers and health disparities in Michigan through two grant proposals: Grant 1: establishment of a community-based dental clinic and a Grant 2: establishment of a community dental health coordinator. Funding for the grant is made possible through the HRSA Grants to States to Support Oral Health Workforce Activities. The grant awards of \$67,200.00 (Grant 1) and \$44,000 (Grant 2) are available for a 9 month period to begin January 1, 2008. The grants are designed to provide initial funds for development and implementation of projects with the expectation that once-established the projects can be sustainable through the billing of services through Medicaid and third-party payors.

ELIGIBLE APPLICANTS

Public and non-profit eligible organizations are eligible to apply. The grant recipients must be located within an existing community-based clinic that offers a full range of healthcare services to populations bearing a disproportionate share of disease and disabilities.

AVAILABILITY OF FUNDING

Grant 1 award will not exceed \$67,200.

Grant 2 award will not exceed \$44,000.

PROJECT PERIOD

Awards will be made for a project period of 9 months beginning January 1, 2008. Applicants are expected to be notified of award decisions by October 31, 2007.

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. The Department will not assume any responsibility or liability for costs incurred by the Contractor prior the signing of an agreement. Funds will be set aside for an independent analysis, contracted at the discretion of the Department, to evaluate the relative merits of all projects funded.

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 the 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 organization and 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's web site: <http://www.cpexpress.state.mi.us/>

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 Oral Health Program, Michigan Department of Community Health, hereafter known as the Department. The issuing office is the sole point of contact for persons/organizations who are considering preparing responses to the RFP. The award will be made to the bidder who most successfully meets the criteria of the RFP, up to the total amount of funds available within the funding level stipulated.

USE OF FUNDS

Funds available under this announcement may not be used to supplant funds for existing projects.

1. Funds for Grant 1 should focus on providing clinical dental services. Funds may be used for materials, supplies and travel associated with implementing the proposed project but should not be the main focus of the proposal.
2. Funds for Grant 2 (community dental health coordinator) should focus on development of a fluoride varnish program for Early Head Start and Head Start Centers, development of a school-based/school-linked dental sealant program, provide oral health education to pregnant women, children and other population groups, provide preventive clinical services, and establishing a dental referral network for comprehensive dental care services. Grant 2 funds may be used to purchase associated portable dental equipment, and for materials, supplies and travel associated with implementing the proposed project but should not be the focus of the proposal.

REQUIRED CAPACITY

1. Matching funds: Matching non-Federal funds of 40% is required. The 40% match cannot be in-kind.
2. In-kind support: In-kind contributions of staff time and other resources are expected both from the applicant and from project partners.

The priority of the community-based dental clinic grant (Grant 1) is to assist in the development of a community-based dental clinic in a community with limited or no access to dental services. The grant may be used to support the increased capacity of an existing community-based dental clinic. The grant is a workforce grant and is established to provide funds to assist in the clinic's infrastructure development through the support of a dentist's salary until which time Medicaid or other reimbursement mechanisms are in place to support the dentist.

The community dental health coordinator position (Grant 2) is designed to facilitate develop a fluoride varnish program for Early Head Start and Head Start Centers, develop a school-based/school-linked dental sealant program, provide oral health education to pregnant women, children and other population groups, provide preventive clinical services, and establish a dental referral network for comprehensive dental care services.

QUESTIONS AND ANSWER PERIOD

A pre-proposal conference will not be held. Questions may be submitted up to October 5, 2007. Written answers will be e-mailed to all parties who have submitted letters of intent and furnished a valid e-mail address.

SPECIFICATIONS

All proposals must address or comply with the following specifications:

- Projects must report quarterly on their effectiveness and progress towards meeting work plan goals. Timely reporting and indicators of success in increasing dental sealant placement for the target population is a goal of these grants.
- A final report including evaluation of the project, statistical data on the number of patients seen, number of patients with disabilities seen, procedures, impact on the community as the result of the project, if the project addresses the goals and objectives of the work plan, and a narrative about the strengths and weaknesses of the program.
- Projects must focus on health status implications of the healthcare services to populations bearing a disproportionate share of disease and disabilities.
- Projects must improve access to oral health prevention measures to include fluoride varnish application and dental sealants for the target population.
- The community dental health coordinator projects must reflect the needs of and demonstrate linkages with the schools.
- Projects must support the Department's goal of increased access to care.
- Projects must be conducted within the State of Michigan.
- Projects must address all requirements of the specifications.

DIRECTIONS FOR COMPLETING THE GRANT APPLICATION:

I. Cover Sheet

A. Project Title: Enter name of project

B. Amount of Request:

C. Name of Applicant Organization: Enter in the name of the applicant 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 Number) 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. Needs Statement -- Include the requested information.

B. Program Description/Work Plan – Attach the program description/work plan. State project goal in space provided. List objectives, activities and outcomes and the quarter in which the objectives will be accomplished in the appropriate columns.

C. Community Involvement, Collaboration, Coordination- Include the requested information. Letters of support should be attached.

D. Organization and Capacity —Include the requested information.

E. Project Sustainability – Include the requested information.

F. Outcome Measures and Evaluation – Include the requested information.

G. Budget Narrative and Summary; Program Budget Cost Detail Schedule-- Using the Budget Completion instructions included in the RFP (see Attachment A), please complete both budget forms (see Attachment B1): DCH-0385 (Budget Summary) and DCH-0386 (Program Budget Cost Detail Schedule). Budget forms should reflect the proposed cost of the project period. Include a budget narrative with the attached forms.

J. Overall Quality of the Proposal-- Include the requested information.

II. Narrative Guidelines

- A. Font:** Please use an easily readable serif typeface, such as Times Roman, Courier, 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 8 ½” 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 page as page 1.
- D. Page Limit:** Page limit is 10 pages; the Title Page, Cover Sheet, Work Plan, Program Budget, and Letters of Support are not included in the page limit.

Primary and Preventive Dental Health Care Services Grant Application

Applications due: October 12, 2007

Cover Page:

A. Project Title: _____

B. Amount of Request: _____

- Cannot exceed \$67,200 for Grant 1 (Community-based dental clinic)**
 Cannot exceed \$44,000 for Grant 2 (Community dental health coordinator)

C. Name of Applicant Organization: _____

Authorized Official: _____

Title: _____

Mailing Address: _____

City: _____ County: _____ ZIP: _____

Telephone: _____ Fax: _____

E-mail Address: _____

D. Contact Person: _____

Title: _____

Mailing Address: _____

City: _____ County: _____ ZIP: _____

Telephone: _____ Fax: _____

E-mail Address: _____

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

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

Public Agency/Unit of a governmental

F. Federal Tax ID 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

II. Selection Criteria: Applications for grants will be reviewed by a committee established by the MDCH. The proposals will be evaluated in terms of clarity, detail, overall understanding of the concepts addressed, and understanding of the Department's objectives for increasing the number of beneficiaries receiving oral health services. Applications will be scored on the following criteria:

A. Needs Statement (15 points)– The needs statement is a concise, descriptive statement identifying the need(s) to be addressed by the project.

1. Applicants will want to provide information of their status as a dental health professional shortage area and identify access to dental providers in the area.
2. Define the specific needs of the target population.
 - a. The target population should include populations bearing a disproportionate share of disease and disabilities
 - b. The barriers that prevent the target population from accessing the proposed service should be described as well as what will be done to overcome these barriers.
3. Describe how activities relate to the project's objectives. Describe how the proposed project will increase dental access for the disadvantaged and disabled population.
4. The application should explain why the request is being made; what need the request will impact; and why the need is not being met with current resources.
5. The need for the project should be supported by local and/or state data.

B. Program Description Narrative/Work Plan (30 points)- Applicants must complete the *Work plan* worksheet and provide a narrative describing the program.

1. The *Work plan* must state the project's goal(s), objectives, performance measure, time frame and person responsible for meeting the objective.
2. The Narrative should a project goal(s) that is a broad statement of purpose. Project objectives should be time-limited and measurable.
3. The narrative should correspond with the *Work plan* in demonstrating how the project will implemented.
4. The narrative should identify how the target population will be informed of services available, describe what services will be performed, and describe community engagement activities.
5. The narrative should demonstrate how the project will:
 - a. increase oral health prevention; and
 - b. **Grant 1: Increase dental access through a community-based clinic; or**
 - c. **Grant 2: Increase oral health education, provide preventive measures (i.e. sealants, fluoride, etc.) and engage the community in improving oral health.**

C. Community Involvement, Collaboration, Coordination (15 points)– The proposal should demonstrate a collaborative community effort or involvement with the program.

1. The project should identify the collaborative partners (i.e. local health departments, local DHS offices, schools, community health centers, professional dental or hygiene associations, etc.) and briefly describe their activities integral to the project. Letters of support should indicate the level of support or involvement of the agencies identified.

2. Describe how the services will integrate with existing health and dental prevention or restorative services in the community focusing on the target population.
3. Provide evidence of past successes in implementing similar projects and/or other evidence that the agency will effectively implement the proposed project.

D. Organization and Capacity (10 points) -- The organization should demonstrate collaboration for comprehensive health care partnerships or experience in partnering with communities.

1. Special consideration will be given to applicants that are located within a community-based clinic that offers a full range of healthcare services to populations bearing a disproportionate share of disease and disabilities.
2. Experience in the provision of oral health services to Medicaid recipients and persons with disabilities should be stated.
3. Describe the project's capacity for staffing and facilities. Describe how staff are or will be qualified to facilitate the project (include education, training, etc.)
4. Describe the volume of patients expected to be served and the services provided.
5. Include an organizational chart defining the key personnel in the project.

E. Project Sustainability (10 points)-- The proposal must demonstrate the capacity to sustain services beyond the nine-month term of the contract.

1. Describe the agency's plan for continuation funding beyond the nine-month grant period.

F. Outcome Measures and Evaluation (25 points): The narrative of outcome measures and evaluation should provide clear, consistent information on how the project will be evaluated in relationship to the goals and objectives.

1. The identified goals and objectives on the *Work Plan* must be consistent with the narrative.
2. Identify the evaluation process included identified, measurable performance objectives for each time-oriented outcome.
3. Describe how outcomes, weaknesses and successes of the program will be measured.
4. Evaluation tools and methods should be identified; how the data will be collected, how often and by whom should be identified.
5. Describe what methods will be used to determine outcomes and successes of the program. The grantee is required to evaluate their program. The evaluation should report on the impact of the program within the community and its impact on improving oral health.
6. Describe what major outcomes or impact on the targeted population are expected as a result of the project. Outcomes should quantify the proposed expected change that the project intends to accomplish.
7. The evaluation measures should specifically include:
 - a. **Grant 1:** *Documentation of dental services placed, number of clients served, and the number of clients with disabilities served.*
 - b. **Grant 2:** *Documentation of baseline mean pit and fissure caries severity in targeted permanent molars among children three years older than target population; the number of sealants placed on molars; retention of sealants;*

participation of the target population; efficiency and effectiveness of the project; and cost-analysis of the program

G. Budget Narrative and Summary (10 points) -- Complete and attach the DCH 0385 and DCH 0386 and include a corresponding budget narrative.

1. Matching non-Federal funds of 40% is required.
2. In-kind support: In-kind contributions of staff time and other resources are expected both from the applicant and project partners.
3. Identify the amount of funds requested and any cost sharing among partners.
4. Include all revenues necessary to support the proposed projects.
5. Descriptions should correspond with information submitted on the DCH 0385 form. Identify the project's fiduciary.
6. Funds available under this announcement for both Grant 1 and Grant 2 should be primarily focused on staff salaries. Funds may be used for materials, supplies and travel associated with implementing the proposed project but should not be the main focus of the proposal.
7. Funds may not be used to supplant funds for existing projects.
8. Funds for Grant 2 (community dental health coordinator) may be used for equipment such as a portable dental unit.

H. Overall Quality of the Proposal (10 points)-- Proposals must demonstrate effective, efficient and ongoing community-based approaches leading to an increase in primary and preventive dental health care services.

1. The proposal demonstrates an effective and efficient program to increase oral health in Michigan.
2. The program demonstrates a reasonable, consistent, sustainable, well-documented plan, that includes methods of implementation and evaluation.

**Michigan Department of Community Health
Primary and Preventive Dental Health Care Services Grant
Notice of Intent to Apply for Funding Form (NOIAF)
Due September 21, 2007 at 5:00 P.M.**

Name of Applicant Organization _____

Federal Tax Identification Number _____

County _____

Type of Applicant Agency

(Check one) { } Not for Profit { } School { } Local Public Health Agency
 { } School of Dentistry or Hygiene { } FQHC
 { } Other (please specify) _____

{ } This letter is to inform you that _____ intends to apply for the MDCH Primary and Preventive Dental Health Care Services Grant.

Grantee will be applying for: (can apply for both grants)

{ } Grant 1 Community-based dental clinic (\$67,200)

{ } Grant 2 Community-based dental health prevention activities (\$44,000)

Authorized Official _____ Title _____

Mailing Address: _____

City: _____ County _____ ZIP _____

Telephone: _____ E-mail address _____ FAX: _____

Contact Person _____ Title _____

Mailing Address _____

City: _____ County: _____ Zip: _____

Telephone: _____ FAX: _____ E-mail Address _____

Signature _____ Date _____

Print Name and Title _____

**Fax (517) 335-8697 or e-mail (semmlers@michigan.gov) this form to:
MDCH/Oral Health**

WORK PLAN – State the overall goal of the project, and list objectives, activities, outcomes and the quarter in which the objectives are expected to be completed in the appropriate column.

Project Goal: _____			
Objectives	Performance Measure	Time Frame	Person Responsible

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
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.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)
PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION
 (continued)

- I. Expenditure Category – 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. 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
 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.

ATTACHMENT B

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)**

PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION (continued)

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.**

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)
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.
- 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. 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 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).
- 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.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)
PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM
PREPARATION (continued)

- K. Salary and Wages Total - Enter a total in the Positions Required column and the Total Salary and Wages column. The total salary and wages amount is transferred to the Program Budget Summary - Salary and Wages expenditure category. If more than one page is required, attach an additional DCH 0386.
- L. Fringe Benefits – Check applicable fringe benefits for employees assigned to 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 Salary and Wages 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 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 - 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, 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 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

ATTACHMENT B

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)**

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

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(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 specified. . Minor items may be identified by general type of cost and summarized as a single item on the Cost Detail Schedule to arrive at a total Other Expenses category. Significant groups or subcategories of costs are described as follows and should be individually identified in the space provided (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.**

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)
PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM
PREPARATION (continued)

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 to be included in this category.
 4. Other - All other items purchased exclusively for the operation of the program and not previously included, 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.

PROGRAM BUDGET SUMMARY

View at 100% or Larger MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
 Use **WHOLE DOLLARS Only**

PROGRAM (A) Budget and Contracts			DATE PREPARED (B) 7/01/xx		Page (C) 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.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
EXAMPLE				
8. TOTAL DIRECT EXPENDITURES (Sum of Lines 1-7)	109,080			109,080
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	109,080			109,080

(J) SOURCE OF FUNDS				
11. FEES & COLLECTIONS	10,000			10,000
12. STATE AGREEMENT	90,000			90,000
13. LOCAL	9,080			9,080
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	109,080			109,080

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

Of 2

View at 100% or Larger

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Use **WHOLE DOLLARS ONLY**

(B) PROGRAM		(C) BUDGET PERIOD		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) 1. SALARY & WAGES POSITION DESCRIPTION	(H) COMMENTS	(I) POSITIONS REQUIRED	(J) TOTAL SALARY	
Nurse	9 month position	1	25,000	
Project Director		.5	18,000	
(K) 1. TOTAL 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	\$400			
3. TOTAL TRAVEL:				\$ 1,400
(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)				
<u>Subcontractor Name</u>	<u>Address</u>	<u>Amount</u>		
ACME Evaluation Services	555 Walnut, Lansing, MI 48933	\$ 2,000		
<u>Subrecipient Name</u>				
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)		8. TOTAL DIRECT EXPENDITURES:		\$ 109,080
(S) 9. INDIRECT COSTS CALCULATIONS		Rate #1: Base \$0 X Rate 0.0000 %		\$ 0
Total				\$ 0
		Rate #2: Base \$0 X Rate 0.0000 % Total		\$ 0
		9. TOTAL INDIRECT EXPENDITURES:		\$ 0
(T) 10. TOTAL EXPENDITURES (Sum of lines 8-9)				\$ 109,080
AUTHORITY: P.A. 368 of 1978		The Department of Community Health is an equal opportunity		
COMPLETION: Is Voluntary, but is required as a condition of funding		employer, services and programs provider.		
DCH-0385 (E) (Rev 2-07) (W) Previous Edition Obsolete. Use Additional Sheets as Needed				

**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 this form to the MDCH contract manager with the final progress report.

Contractor Name: Michigan Agency Contract #: 2008000 Date: 10/31/07

Quantity	Item Name	Item Specification	Tag Number	Purchase Price
1	LW Scientific M5 Labscope	<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 	N0938438EW098	\$ 5,000
				\$
		EXAMPLE		\$
				\$
				\$
				\$
				\$
Total				\$ 5,000

Contractor's Signature: _____ Date: _____

PROGRAM BUDGET SUMMARY
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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

PROGRAM			DATE PREPARED		Page	Of
CONTRACTOR NAME			BUDGET PERIOD			
MAILING ADDRESS (Number and Street)			From To:		AMENDMENT #	
CITY	STATE	ZIP CODE	BUDGET AGREEMENT		FEDERAL ID NUMBER	
			<input type="checkbox"/> ORIGINAL <input type="checkbox"/> AMENDMENT			
EXPENDITURE CATEGORY					TOTAL BUDGET (Use Whole Dollars)	
1. SALARIES & WAGES						
2. FRINGE BENEFITS						
3. TRAVEL						
4. SUPPLIES & MATERIALS						
5. CONTRACTUAL (Subcontracts/Subrecipients)						
6. EQUIPMENT						
7. OTHER EXPENSES						
9. TOTAL DIRECT EXPENDITURES (Sum of Lines 1-7)			\$0	\$0	\$0	\$0
9. INDIRECT COSTS: Rate #1 %						
INDIRECT COSTS: Rate #2 %						
10. TOTAL EXPENDITURES			\$0	\$0	\$0	\$0

SOURCE OF FUNDS

11. FEES & COLLECTIONS						
12. STATE AGREEMENT						
13. LOCAL						
14. FEDERAL						
15. OTHER(S)						
16. TOTAL FUNDING			\$0	\$0	\$0	\$0

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

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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	
1. 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		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-0386 (E) (Rev 2-07) (W) Previous Edition Obsolete. Use Additional Sheets as Needed				