Agency Name _____

Personal Service	**FTEs**	**AMOUNT BILLED TO WIC**	**In-Kind**
Program Support	0.00	$0	$0
Non-Direct Staff**	0.00	$0	$0
Competent Professional Authority	0.00	$0	$0
Total FTEs and Salary	0.00	$0	$0
Fringe Benefits		$0	$0
Non-Direct Fringe Benefits		$0	$0
Total Personal Service and Fringe Benefits (a)		$0	$0
Other Than Personal Service			
Space		$0	$0
Other Non-Personal Service*		$0	$0
Subtotal Other Than Personal Service (b)		$0	$0
Total Direct Costs (a+b)		$0	$0
Indirect Costs (c)**		$0	$0
Subtotal (a+b+c)		$0	$0
Breast Pumps and Collection Kits		$0	$0
Subtotal Allowable Reimbursement		$0	$0

Refer to the instructions in Attachment 18 and then use the budget back-up forms to justify the costs and budgeted amounts for each of these categories, include the budgeted total for these categories.

* The “Other Non-Personal Service” line includes Program Operations, Travel, Equipment, Audit, and Other. Use the budget back-up forms to justify the costs and budgeted amounts for each of these categories and include the budgeted total for these categories in the “Other Non-Personal Service” line.

** WIC will limit Indirect and Non-direct program related costs to 10 percent of the total budget.

Additional Budget Notes

Program Support

Additional Program Support Notes

Title	First Name	Last Name	Effective Date	Hours in Agency Work Week	Hours Worked in Week	Hours Devoted to WIC	FTE	Annualized Salary	Justified Amount	Amount Billed to WIC	Billed FTE	Is WIC Coord-inator
			10/1/2009						$0	$0	0.00	☐

Total Billed Program Support Costs	**0.00**		**$0**
Total In-Kind Program Support Costs	***0.00***		***$0***

Non-Direct Staff

Additional Non-Direct Staff Notes

Title	First Name	Last Name	Effective Date	Hours in Agency Work Week	Hours Worked in Week	Hours Devoted to WIC	FTE	Annualized Salary	Justified Amount	Amount Billed to WIC	Billed FTE
			10/1/2009						$0	$0	0.00

Total Billed Non-Direct Staff Costs	**0.00**		**$0**
Total In-Kind Non-Direct Staff Costs	***0.00***		***$0***

Competent Professional Authority

Additional Competent Professional Authority Notes

Title	First Name	Last Name	Effective Date	Hours in Agency Work Week	Hours Worked in Week	Hours Devoted to WIC	FTE	Annualized Salary	Justified Amount	Amount Billed to WIC	Billed FTE	Is WIC Coord-inator
			10/1/2009						$0	$0	0.00	☐

Total Billed Competent Professional Authority Costs	**0.00**		**$0**
Total In-Kind Competent Professional Authority Costs	***0.00***		***$0***

Fringe

Additional Fringe Notes

Total Justified Direct Salaries: **$0**

Component Name	Positions to which Component Applies / Calculation Methodology	Total Salaries	Rate (%)	Justified Amount	Billed Amount
Total Justified Fringe Costs				**$0**	
Total Billed Fringe Costs				**$0**	

In-Kind Fringe Costs ***$0***

Non-Direct Staff Fringe

Additional Non-Direct Staff Fringe Notes

Total Justified Non-Direct Salaries: **$0**

Component Name	Positions to which Component Applies / Calculation Methodology	Total Salaries	Rate (%)	Justified Amount	Billed Amount
Total Justified Non-Direct Staff Fringe Costs				**$0**	
Total Billed Non-Direct Staff Fringe Costs				**$0**	

In-Kind Non-Direct Staff Fringe Costs ***$0***

Space

Additional Space Notes

Site Number	Site Name	Permanent	Proposed Caseload	Justified Cost	Billed Amount
		☐		$0	$0
Total Justified Space Costs			**0**	$0	
Total Billed Space Costs				**$0**	
Total In-Kind Space Costs				***$0***	

Other Non-Personal Service Summary

Category	Justified Amount	Billed Amount	*In-Kind*
Program Operations	$0	$0	*$0*
Travel	$0	$0	*$0*
Equipment	$0	$0	*$0*
Audit	$0	$0	*$0*
Other	$0	$0	*$0*
Total Other Non-Personal Service Costs	$0	$0	*$0*

Program Operations

Additional Program Operations Notes

Description	Justification	Justified Amount	Billed Amount	Additional Budget Line Comments
Office Supplies				
Medical Supplies				
Education Materials				
Printing				
Equipment Leases				
Telecommunications	Details on next sheet	$0	$0	
Postage				
Total Justified Program Operations Costs		**$0**		
Total Billed Program Operations Costs		**$0**		
Total In-Kind Program Operations Costs		***$0***		

Program Operations - Telecommunications Detail

Expense Name	Monthly Cost	Number of Lines Allocated to Program	Number Of Months	Justified Amount	Billed Amount	Additional Budget Line Comments
			12	$0	$0	
Total Telecommunications Cost				**$0**	**$0**	

Travel

Additional Travel Notes

Local Travel

Justification	Justified Amount	Billed Amount	Additional Budget Line Comments

Non - Local Travel

Description/Location	Total # Positions/Titles	Anticipated Date(s) of Travel	Justified Amount	Billed Amount	Additional Budget Line Comments

Total Justified Travel Costs	**$0**
Total Billed Travel Costs	**$0**
Total In-Kind Travel Costs	**$0**

Equipment

Additional Equipment Notes

Item Description	Quantity Requested	Replacement	Use at Site #s	Purpose/Explanation of Need for Item	Unit Cost	Justified Amount (Unit Cost * Quantity)	Billed Amount	Additional Budget Line Comments
		☐				$0	$0	
Total Justified Equipment Costs						**$0**		
Total Billed Equipment Costs						**$0**		

Total In-Kind Equipment Costs **$0**

Audit

Additional Audit Notes

Audit Costs	
Time Period of Audit for Which Funding is Requested (Agency Fiscal Year, not necessarily the WIC Local Agency contract year):	Start Date: End Date:
Estimated Date the Audit Will be Submitted to the State* (The audit is due to both Clearinghouses either nine (9) months after the end of the sponsoring agency's fiscal year **OR** within 30 days of the audit completion date, **whichever comes first.**)	
Methodology to Calculate the Amount Requested:	
A.) Total Cost of Audit (Total cost for entity-wide financial AND A-133 Single Audit)	
B.) Total Sponsoring Agency Expenditures for Period Audited (Total entity expenditures per Statement of Activities or Expenses in financial report for ALL programs including WIC and redeemed WIC Food Checks)	
C.) Total WIC Local Agency Contract Expenditures for Period Audited (Includes all WIC Contract dollars expended during the audit period PLUS all redeemed WIC Food Checks, Breast Pumps, and FMNP)	
D.) Percent of WIC Contract Expenditures to Agency Total Expenditures (C / B) (To 2 decimal places)	0.00 %
E.) Maximum Allowable WIC Program Share of Audit Cost (A x D)	$0
Total Billed Audit Cost	$0
Total In-Kind Audit Cost	$0

ONPS Other

Additional ONPS Other Notes

Item Description	Purpose/Explanation of Need for Item	Justified Amount	Billed Amount	Additional Budget Line Comments
Total Justified ONPS Other Costs		**$0**		
Total Billed ONPS Other Costs		**$0**		
Total In-Kind ONPS Other Costs		**$0**		

Indirect Costs

Additional Indirect Cost Notes

Situation	Rate (%)
☐ Agency has a Federally approved rate	
☐ Agency has applied for a Federally approved rate	
☐ NONE PRESENTLY IN USE	

Supported Indirect Rate (%)	Total Allowable Costs	Justified Amount	Billed Amount (cannot exceed 10%)	Billed Rate (cannot exceed 10%)	In-Kind Amount
0.00	$0	$0		0.00 %	$0

Breast Pump Costs

Additional Breast Pump Cost Notes

Breast Pump Brand & Model	Rental	Monthly Cost	Cost Per Year	Number of Pumps	Total Pump Cost	Sales Tax	Shipping	Justified Cost
	☐				$0	$0	$0	$0
Total Breast Pump Costs								**$0**
Collection Kit Brand and Model			**Cost Per Year**	**Number of Kits**	**Total Kit Cost**	**Sales Tax**	**Shipping**	**Justified Cost**
					$0	$0	$0	$0
Total Collection Kit Costs								**$0**
Total Breast Pump & Collection Kits Costs								**$0**