

Print Version Only.

Agency Name _____

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Personal Service	FTEs	AMOUNT BILLED TO WIC	In-Kind
Personal Service	0.00	\$0	\$0
Non-Direct Staff ^{**}	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
GRAND TOTAL (a+b+c)		\$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 VMA will limit indirect and non-direct program related costs to 10 percent of the total budget.

Federal funds are being used to support this contract. The Code of Federal Domestic Assistance (CFDA) number for these funds is 10.557.
Additional Budget Notes

Personal Service

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Additional Personal Service Notes

Title	First Name	Last Name	Effective Date	Work Week Hours	Hours Worked Per Week	Hours Devoted to VMA	FTE	Annualized Salary	Justified Amount	Amount Billed to WIC	Billed FTE	Is VMA Director
			10/1/2008						\$0	\$0	0.00	<input type="checkbox"/>

Total Billed Personal Service Costs	0.00		\$0
Total In-Kind Personal Service Costs	0.00		\$0

Non-Direct Staff

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Additional Non-Direct Staff Notes

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Title	First Name	Last Name	Effective Date	Work Week Hours	Hours Worked Per Week	Hours Devoted to VMA	FTE	Annualized Salary	Justified Amount	Amount Billed to WIC	Billed FTE
			10/1/2008						\$0	\$0	0.00

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

Fringe

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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

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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

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Additional Space Notes

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Site Number	Site Name		Justified Cost	Billed Amount
			\$0	\$0
Total Justified Space Costs		0	\$0	
Total Billed Space Costs			\$0	
Total In-Kind Space Costs		0	\$0	

Other Non-Personal Service Summary

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Category	Justified Amount	Billed Amount	<i>In-Kind</i>
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

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Additional Program Operations Notes

Description	Justification	Justified Amount	Billed Amount	Additional Budget Line Comments
Office Supplies				
Informational/Educational/Retention Materials				
Printing and Reproduction				
Equipment Leases/Maintenance Contracts				
Telecommunication Costs	Details on next sheet	\$0	\$0	
Postage/Delivery				
Total Justified Program Operations Costs		\$0		
Total Billed Program Operations Costs		\$0		

Total In-Kind Program Operations Costs

\$0

Program Operations - Telecommunications Detail

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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

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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

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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
		<input type="checkbox"/>				\$0	\$0	
Total Justified Equipment Costs						\$0		
Total Billed Equipment Costs						\$0		
Total In-Kind Equipment Costs							\$0	

Audit**Print Version Only.****If audit costs are included in the sponsoring agency's indirect cost calculations, DO NOT complete this form.****This version cannot be filled out.****Additional Audit Notes**

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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

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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

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Additional Indirect Cost Notes

Situation	Rate
<input type="checkbox"/> Agency has a Federally approved rate	
<input type="checkbox"/> Agency has applied for a Federally approved rate	
<input type="checkbox"/> NONE PRESENTLY IN USE	

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