FIRST CONNECTIONS INTERNAL RFP

APPENDIX I. COST PROPOSAL TEMPLATE

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CONTRACT PERIOD | | FROM: | October 1, 2018 | TO: | | September 30, 2019 | |
| AGENCY |  | | | | DATE | |  |
| ADDRESS |  | | | | TELEPHONE | |  |
| PROGRAM | First Connections | | | | FEIN# | |  |
| SERVICE AREA |  | | | | | | |

PART 1: RIDOH Reimbursable Costs per Non-Medicaid Visits

|  |  |  |  |
| --- | --- | --- | --- |
|  | Number of annual non-Medicaid eligible visits | Per-visit rate | Subtotal |
| Nurse visits |  | $104.95 |  |
| Social worker visits |  | $84.00 |  |
| Community health worker visits |  | $70.00 |  |
| Total RIDOH Reimbursable Non-Medicaid Visit Cost: | | | $0.00 |

**PART 2: Flexible Funding Costs**

|  |  |
| --- | --- |
| **Expense Category** | **Budget** |
| 1. Personnel | $ |
| 1. Care Coordination | $ |
| 1. In-State Travel | $ |
| 1. Performance Incentives | $ |
| 1. Printing/Copying | $ |
| 1. Supplies | $ |
| 1. Professional Development/Training | $ |
| 1. Postage | $ |
| 1. Other | $ |
| 1. | $ |
| 2. | $ |
| 1. Equipment | $ |
| **Sub-Total** | **$** |
| Indirect/Administrative Cost | $ |
| **Total** | **$** |

Note: Offerors need not allocate dollars to all categories listed.

APPENDIX J. SAMPLE BUDGET WORKSHEET

*Use this format to submit your budget. All items included in this Budget Form must be fully explained in the Budget Narrative. The Organization In-Kind Contribution may not be less than 10% of the requested funding.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Expense Category Detail** |  |  |  |
| Personnel (Name, Title) | Hourly Rate | Total # of Hours | Total |
|  |  |  |  |
|  |  |  |  |
| Fringe Benefits (provide breakdown of fringe benefits) | Fringe % Rate |  | Total |
|  | % |  |  |
|  | % |  |  |
| Care Coordination |  |  | $ |
| In-State Travel | X @ # of miles | | $ |
| Performance Incentives |  | | $ |
| Printing/Copying |  | | $ |
| Supplies |  | | $ |
| Professional Development and Training |  | | $ |
| Postage |  | | $ |
| Other: (if your expense does not fit into a category above please list and specify below) |  |  | $ |
|  |  | |  |
|  |  | |  |
| Equipment |  | |  |
| Indirect Costs/Admin Costs\* |  | |  |
| 10% verifiable match will come from |  | |  |
| **Total Request** |  | |  |

\*If including indirect charges in the budget, a copy of your federally approved indirect rate must be attached. If you do not have a federally approved indirect rate, you may charge a 10% de minimus rate.

**PART 3: Sum of total Reimbursable and Flexible Funding Costs**

|  |  |
| --- | --- |
| **TOTAL COST PROPOSAL AMOUNT FOR THIS SERVICE AREA:** | **$0.00** |

**PART 4: Please attach typed budget narrative justifying the above costs.**