



Doing Business with Passaic County Department of Human Services

How apply for funding for your projects

Agenda

1. About Passaic County Department of Human Services
2. Funding Streams and Requirements
3. Needs Assessment and Planning
4. Funding Availability and Time Frames
5. RFP
6. Budgeting & Reporting
7. Questions



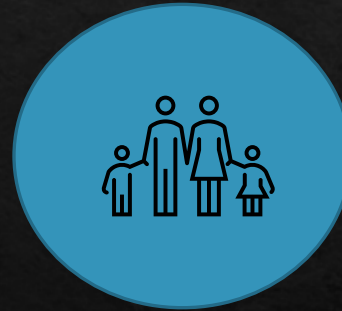
Passaic County Department of Human Services Divisions



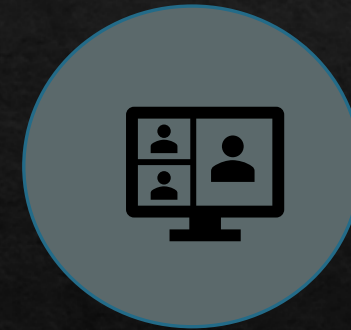
Community
Services



Mental
Health and
Addiction
Services



Youth
Services



Workforce
Development

Funding Streams and Requirements

- ◆ Transportation, Social Services for the Homeless, and Intensive Case Management
- ◆ Peer Grouping
- ◆ County Human Services Advisory Council
- ◆ Homeless Trust
- ◆ Alcohol Education, Rehabilitation and Enforcement Fund (AEREF) and County Match
- ◆ Innovations Grant
- ◆ GCADA
- ◆ County Mental Health Board
- ◆ Family Court and State Community Partnership
- ◆ HUD CoC Program
- ◆ CSBG
- ◆ Other Special Initiatives
- ◆ County Dedicated Funding

Transportation, Social Services for the Homeless, and Intensive Case Management

New Jersey Division of Family Development

Annually Renewing: January to December

\$2.3 M

Homeless prevention, transportation and case management services (and Code Blue)

Services are for income eligible, TANF, SSI, and NJ211 referred

Alcohol Education, Rehabilitation and Enforcement Fund (AEREF)

Funding

\$1.1 Million
Annually

County Cash
Match Required

Requirements

County
Comprehensive
Plan

Minimum for
Education and
Detox

Services

Prevention
Early Intervention

Treatment
Recovery Support

Family Court and State Community Partnership



Annual Allocation of \$1.4 million



Requires a 3 Year Plan with Annual Updates



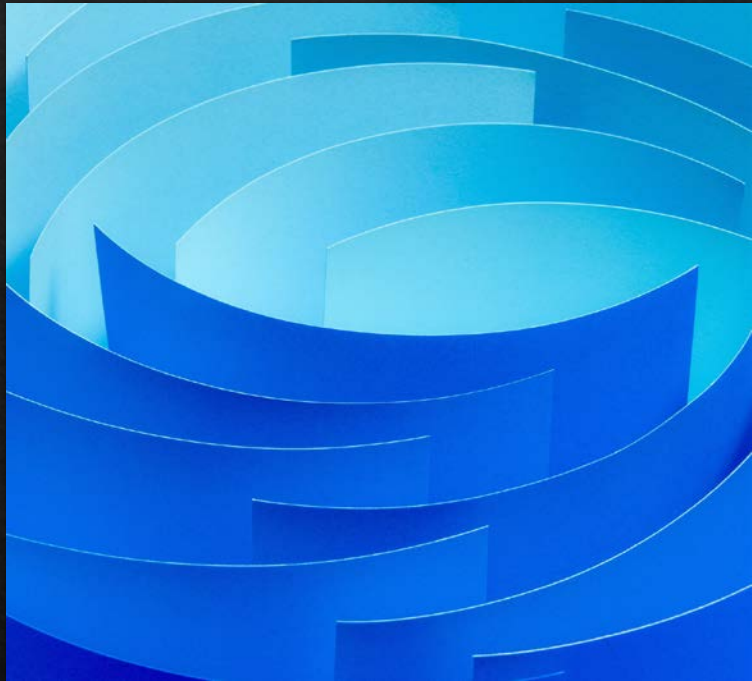
Youth Services Commission must approve allocations



Services are provided across a continuum from Prevention to Re-Entry

Funding Availability and Time Frames





Anatomy of a Request for Proposals (RFP)

www.passaicbids.com

The Important Stuff

Be sure to:

- Sign in to download the documents so you can be notified of any addenda
- Follow the checklist and include required attachments, secure signatures and notary
- Pay close attention to timeframes and due dates
- Pay close attention to submission guidelines and instructions
- Attend the bidders conference
- Ask questions EARLY
- Plan ahead and submit your proposal EARLY



REQUEST FOR PROPOSALS

for
Collective Impact 2020
For the Passaic County Humans Services Department
RFP-20-023

2020

PASSAIC COUNTY BOARD OF CHOSEN FREEHOLDERS

Cassandra "Sandi" Lazzara, Director
Pat Lepore, Deputy Director
John Bartlett
Theodore "TJ" Best
Bruce James
Terry Duffy
Assad Akhter

Sherry Arvanitakis, QPA
Purchasing Agent
County of Passaic
Passaic County Procurement Center
495 River Street
Paterson, New Jersey 07524
Phone: (973) 247-3300
Fax: (973) 742-8295

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Bid Document Checklist

The following documents must be included with the Respondent's Bid:

Document Description	Authority
Acknowledgment of Receipt of Addenda	N.J.S.A. 40A:11-23.2 (e)
Statement of Corporate Ownership	N.J.S.A. 52:25-24.2
Bid Proposal	N.J.S.A. 40A: 11-4
Standard Questionnaire	N.J.S.A. 40A:11-26

The following internal RFP Narrative Document Checklist due at bid opening:

Document Description	Authority
Annex A-1 - Contract Summary Sheet: Identifying information of the applicant agency and project name for which funding is sought	Internal
Annex A-2 – Program Information form.	Internal
Annex A-3 – Program Narrative: Detailed narrative of no more than 10 typed pages in length.	Internal
Annex A-4 – Levels of Service Form	Internal
Annex A-5 – Outcomes Form	Internal
Annex A-6 – Budget Narrative Form	Internal
Annex B - Full Budget for the project	Internal
Annex C-1 (Part 1 and 2) - County Requirements	Internal
Annex C-2 – Special Conditions (if applicable)	Internal
Annex D – Contract Signatures and Agreement	Internal
Job descriptions for new or vacant positions and resumes for existing staff who will be working with the proposed program.	Internal
Supporting documents: Include a copy of all Memoranda of Understanding with other corporations, agencies, or programs referenced in your proposal.	Internal
Include this completed checklist with your attachments	Internal

The following documents must be submitted to the County prior to the contract being executed:

Document Description	Authority
Disclosure of Investment Activities in Iran	N.J.S.A. 52:32-57 (P.L. 2012, c. 25)
Certification of Non-Involvement in Prohibited Activities in Russia or Belarus	N.J.S.A. <u>52:32-60.1</u> , et seq. (P.L. 2022, c.3)
Non-Collusion Affidavit	N.J.S.A 52:34-15
MBE/WBE Program Certification Form (if applicable)	Resolution No. R20210933
Form W-9, Department of the Treasurer Internal Revenue Service	Internal
Business Registration Certificate	N.J.S.A. 52:32-44
Attach a copy of the sliding scale schedule if applicable	Internal
Attach a copy of the facility DMHAS outpatient license, or provider license if applicable as per the eligibility criteria	Internal
Table of Organization	Internal
Board of Directors List	Internal

Name of Bidder (Please Print): _____

Signature of Authorized Representative: _____

Name (Please Print): _____

Title (Please Print): _____ **Date:** _____

**All documents required for the bid submission and prior to the execution of Agreement to the winning bidder are appended hereto and labeled accordingly. If any of the documents stated herein are missing, please contact the Passaic County Purchasing Agent immediately.*

NOTE: BID DOCUMENT RETURN ENVELOPES MUST CLEARLY IDENTIFY THE BID NAME, BID NUMBER, AND BID OPENING DATE ON THE EXTERIOR OF THE COMMON CARRIER OR COMPANY MAILING ENVELOPE.



Scope of Work

- ◆ This section of the RFP spells out everything you need to know including:
 - Who is eligible to apply
 - Any licensing requirements
 - Target populations to be served
 - General fiscal standards
 - General program standards
 - **Projects for which proposals are being solicited**

II. Deliverables and Requirements for Youth Mental Health Demonstration Project Grant Administered by The County Department of Human Services

Applicants need to submit one (1) original and three (3) complete copies, including one on a flash drive. To apply, please complete Annex A documents. Annex A is a separate fillable PDF document downloadable with the RFP materials. Applicants are advised to ensure they have downloaded the RFP, along with Annex A and Annex B.

1. Annex A-1 - Contract Summary Sheet: A form providing identifying information about the agency applying and the project for which funding is sought.
2. Annex A-2 - Program Information form.
3. Annex A-3 - Program Narrative: Complete a detailed narrative of no more than 10 typed pages in length. The following sub-headings may be used to organize the narrative and its topics:
4. Annex A-4 – Proposed Outputs
5. Annex A-5 – Budget Narrative Form
6. Annex C 1 and 2 forms include other requirements specific to this program or funding source if applicable.
7. Annex D: Complete and sign the agreement to the terms of the RFP.
8. **Proposed Budget**

Proposal Contents

COUNTY OF PASSAIC
Department of Human Services

ANNEX A-1 – CONTRACT SUMMARY SHEET


Provider Agency: _____ Contract #: _____
Mailing Address: _____ Federal ID: _____
City, State, and Zip: _____
Organization Type: Private Non-Profit Private for Profit
 Public/Government Educational Institution
 Other (Specify) _____

Agency Official: _____ Title: _____
Mailing Address: _____
Telephone: _____ Fax Number: _____
Email Address: _____

Name of Program: _____
Executive Summary:

All routine notices relevant to the operations of this program should be sent to the following individual(s):

Name and Title: _____
Mailing Address: _____
Telephone: _____ Fax Number: _____
Email Address: _____

Contract Signature:  _____
Printed Name: _____ Title: _____
Date: _____

Annex A-1 Contract Summary Sheet

Annex A-3 Program Narrative

ANNEX A-3 – PROGRAM NARRATIVE

Agency Name: _____

Program Name: _____

Section 1: Description of Applicant Agency

Section 2: Narrative Description of Program (attach additional pages as necessary)



The Narrative

A well written proposal is key to getting funding for your project idea.

No matter how good an idea is, it may not get funded if you can't convey this project idea in your proposal.

Deliverables

◆ **Narrative tips:**

- ❖ Number the pages of your narrative, pages are separated during the review process
- ❖ Use the numbering and lettering that is used in the RFP
- ❖ Be as detailed as possible
- ❖ Keep your audience in mind
- ❖ Put your best foot forward
- ❖ Include data, especially about the problem your program is designed to solve
- ❖ Sell it!

COUNTY OF PASSAIC
Department of Human Services

ANNEX A-4 – Proposed Outputs

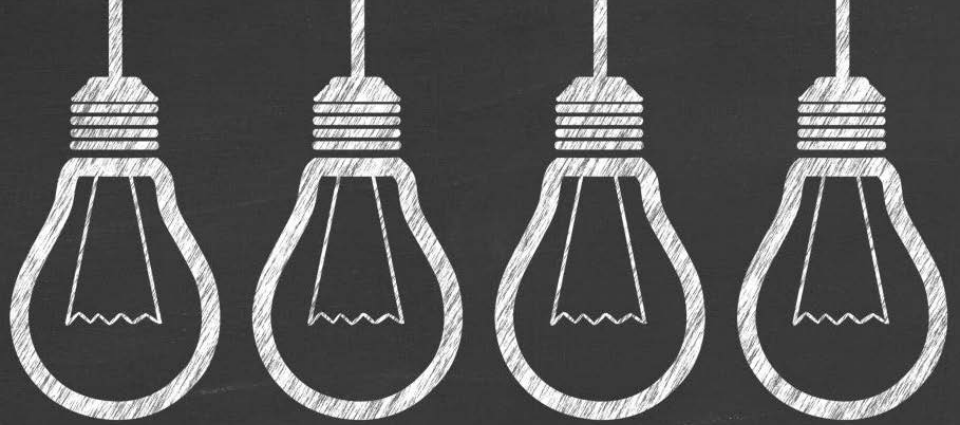
Agency Name: _____
Program Name: _____

Use this form to identify the anticipated number of people to be served and the modality. Some examples can include psychiatry, individual, group or family therapy, case management, etc.

A. Service Type (example: meals, individual sessions, bus pass, van trip, etc.)	B. Anticipated number to be served

Anticipated Impact #1:	
Measurable Outcome # 1:	
Measurable Outcome # 2:	
Measurable Outcome # 3:	
Evaluation Methods:	
Anticipated Impact #2:	
Measurable Outcome # 1:	
Measurable Outcome # 2:	
Measurable Outcome # 3:	
Evaluation Methods:	

Annex A-4 Proposed Outputs



SMART Goals

Specific

Measurable

Achievable

Relevant

Time
Bound

<https://www.samhsa.gov/sites/default/files/nc-smart-goals-fact-sheet.pdf>

Measurable Outcome Exercise

Anticipated impact: Allow individuals and families access to food items locally.

Outcome #1: Ability to feed families on a regular basis.

Outcome # 2:
Access to wraparound services provided through the pantry.

Outcome # 3:
Increase number of families applying for TANF.

ANNEX A-5 – BUDGET NARRATIVE

Agency Name: _____
Program Name: _____

Please provide narrative description and explanation of budget items. Explain how grant funding will be utilized:

[Large empty light blue box for narrative description]

Annex A-5 Budget Narrative

COUNTY OF PASSAIC
Department of Human Services

ANNEX C-1 – COUNTY REQUIREMENTS (Part 1 of 2)

Agency Name: _____
Program Name: _____
Contract #: _____ Contract Period: From _____ To _____

The County of Passaic is offering this contract as a:

- Fee for Service Contract: **MUST ATTACH ANNEX B-2 BUDGET**
- Cost Reimbursement (Deficit Cost) Contract: **MUST ATTACH ANNEX B BUDGET**
- Other (Specify): _____

Reporting Requirements:

All fiscal and programmatic reports must be submitted via email to:
hsinvoices@passaiccountynj.org

- Monthly level of service and fiscal reports shall be submitted to the county by the 15th of each month following the reporting period.
- Quarterly level of service and fiscal reports shall be submitted to the county according to the following schedule:
 - Quarter 1: Begins: _____ Ends: _____ Quarterly report due by: _____
 - Quarter 2: Begins: _____ Ends: _____ Quarterly report due by: _____
 - Quarter 3: Begins: _____ Ends: _____ Quarterly report due by: _____
 - Quarter 4: Begins: _____ Ends: _____ Quarterly report due by: _____

COUNTY OF PASSAIC
Department of Human Services

ANNEX C-1 – COUNTY REQUIREMENTS (Part 2 of 2)

Agency Name: _____
Program Name: _____
Contract #: _____ Contract Period: From _____ To _____
Contract Ceiling: _____

Advisory Committee Attendance:

As a condition of accepting this contract with the County of Passaic Department of Human Services your agency is required to have representation on, and comply with the attendance requirements of the following advisory committees:

- Mental Health and Addiction Professional Advisory Board
- Youth Services Commission
- Passaic County Interagency Council on Homelessness
- County Alliance Steering Subcommittee
- Workforce Development Board
- Multi-Disciplinary Team
- Other (Specify) _____
- Other (Specify) _____
- Other (Specify) _____
- Not applicable for this contract

Other Reporting Requirements:

In addition to the county's reporting requirements above, some grants require entry into a database. The provider agency is responsible to secure and maintain access to the database and to enter data according to each system's requirements. The requirements of this contract include the provider agency to enter data into the following systems:

- HMIS
- CIMS
- JAMS
- SAGE
- EMPOWR
- Other (Specify) _____
- Not applicable for this contract

Annex C-1 County Requirements (part 1 and 2)

Annex C-2 Special Conditions

COUNTY OF PASSAIC
Department of Human Services

ANNEX C-2 – SPECIAL CONDITIONS

Agency Name: _____
Program Name: _____
Contract #: _____ Contract Period: From _____ To _____

The following requirements or special conditions apply to this contract:

Annex D Contract Signatures and Agreement

COUNTY OF PASSAIC
Department of Human Services

ANNEX D- CONTRACT SIGNATURES AND AGREEMENT

Agency Name: _____
Program Name: _____
Contract #: _____ Contract Period: From _____ To _____

The terms of this contract have been read and understood by the persons whose signatures appear below.

Provider Agency Authorized Signature

Signature

Printed Name

Title

Date



The background of the slide is a dense field of 3D-rendered numbers in various sizes and orientations. The numbers are primarily in shades of light blue and white, creating a sense of depth and movement. Some numbers are larger and more prominent, while others are smaller and recede into the background. The overall effect is a complex, abstract pattern of digits.

Budgeting & Reporting

Training

Cost Basis: Types of Contracts



DEFICIT FUNDED



FEE FOR SERVICE

Deficit Funded Contracts



Most popular type of contract awarded



A method for reimbursement based on the difference between expenditures incurred by the provider agency and revenues they have received during the reporting period



Dollar amount reported on the Annex B must match the Level of Service (LOS) Report provided by the agency



Requires Form **Annex B** for budgeting and reporting

Fee For Service Contracts

Abbreviated as F.F.S.

A method for reimbursement based on payment for specific services rendered

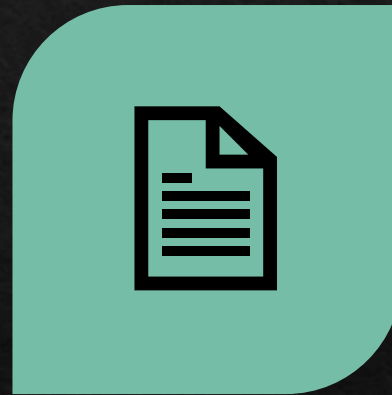
Dollar amount reported must match the Level of Service (LOS) Report provided by the agency, and agree with contract unit rates

Requires Form Annex B-2 for budgeting and reporting

What is an Annex B



FORM USED FOR COST-RELATED
CONTRACTS



PROVIDED FOR UNIFORMITY IN THE
PREPARATION OF CONTRACT BUDGETS AND
EXPENDITURE REPORTS WHILE ALLOWING
FOR VARIATIONS THAT OCCUR AMONG
CONTRACTS AND INDIVIDUAL PROVIDER
AGENCIES' BOOKS AND RECORDS.



IDENTIFIES THE FULL ALLOCABLE COSTS OF
SERVICES TO BE PROVIDED FOR THE LENGTH
OF THE CONTRACT

Annex B: Contract Information Form

- ◇ The purpose of the Annex B: Contract Information Form is to provide general information about the provider agency, the contracts it has with the Department and other organizations and agencies, and the services it provides.
- ◇ Majority of Contract Information Form is completed by the Passaic County DHS Division Director including:
 - ◇ Provider Agency (Agency Name)
 - ◇ Contract Number
 - ◇ Fiscal Report Period
 - ◇ indicate the beginning and ending date of the period covered by the attached budget
 - ◇ Fund Source (Column 1)
 - ◇ Grant or County Budget Name utilized to fund the contract and services provided
 - ◇ Contract Ceiling Amount (Column 2)
 - ◇ indicate the contract reimbursable ceiling
 - ◇ Program Column Number (Column 3)
 - ◇ indicate the column number used for each program in the Annex B: Contract Expense Summary. Use the same column # and program name throughout the package.
 - ◇ Contract Payment Costs Basis (Column 4)
 - ◇ Indicate the payment method: deficit funded or fee for service

1	(Revised October, 2002)	Passaic County Human Services Department	Prepared for: (Check Appropriate Boxes)		
2			<input type="checkbox"/> Proposal Budget <input type="checkbox"/> Contract Budget <input checked="" type="checkbox"/> Fiscal Report for:		
3	Provider Agency: AGENCY NAME	ANNEX B: CONTRACT BUDGET INFORMATION			
4	Contract Number: CONTRACT NUMBER HERE			Period from 00/00/00 to 00/00/00	
5	Submission Date: DATE HERE				
6					
7	First 4 Columns of This Table to be Completed by Human Service Department Staff Only. Please Fill in all Other Information and Sign				
8					
9	Fund Source	Contract	Program	Contract Payments	Grantee
10	(Describe)	Ceiling	Column	Cost Basis	Contact
11		Amount	Number	(Specify Type)	Person
12	(1)	(2)	(3)	(4)	Number
13					
14		\$	-		
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30	I certify that the cost data used to prepare this document are accurate,				If this is a contract budget modification, indicate
31	complete, current and consistent with procedures and requirements				the Modification Number below:
32	established by the Passaic County Human Services Department.				
33	Name & Title:				Contract Modification #:
34	Signature:				
35	Date:				
36					

Annex B: Contract Information Form

- ◆ The provider agency is responsible to complete the following:
 - ◆ Grantee Contact Person and Phone Number
 - ◆ indicate the name and telephone number of the individual within the provider agency who is knowledgeable of the contract and can answer questions about the contract budget
 - ◆ Certify the bottom of the form
 - ◆ The provider agency authorized signatory or fiscal officer must certify to the completeness/accuracy of the budget or expenditure report as submitted or it is considered invalid
 - ◆ Name & Title
 - ◆ Signature
 - ◆ Date

Annex B: Contract Expense Summary

Program Columns:	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Budget Category (See Schedules for Detail)	Grand Total	Subtotal Other	Subtotal County Contract	YYYY Grant Title Program Name	YYYY Grant Title Program Name	YYYY Grant Title Program Name	YYYY Grant Title Program Name	YYYY Grant Title Program Name	YYYY Grant Title Program Name	YYYY Grant Title Program Name	YYYY Grant Title Program Name	YYYY Grant Title Program Name	YYYY Grant Title Program Name	General & Administrative Costs
A. Personnel Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B. Consultants & Professional Fees	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C. Materials & Supplies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
D. Facility Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E. Specific Aid to Clients	0	0	0	0	0	0	0	0	0	0	0	0	0	0
F. Other Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0
G. Gen. & Admin. Dollar Allocation			0											
H. Gen. & Admin. Percent Dist.	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
I. Subtotal Operating Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
J. Equipment Purchases	0	0	0	0	0	0	0	0	0	0	0	0	0	0
K. Total Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
L. Provider Revenues	0	0	0	0	0	0	0	0	0	0	0	0	0	0
M. Net Cost	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
N. Service Units Provided		0		0	0	0	0	0	0	0	0	0	0	0
O. Agency Total Unit Cost	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
P. County Unit Cost	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

CROSS
CHECK

Annex B: Contract Expense Summary

M	N	O
Prepared for: (Check Appropriate Boxes)		
(<input checked="" type="checkbox"/>) Proposal Budget		
(<input type="checkbox"/>) Contract Budget		
(<input type="checkbox"/>) Fiscal Report for:		
Period from 00/00/00 to 00/00/00		

- ◆ This form summarizes the provider agency's expense information for the applicable budget period. It will be calculated and completed *after* the Annex B: Contract Expense Detail forms and all supporting schedules have been completed **as it is linked with formulas**.
 - ◆ Built in formulas are there for efficient and more accurate budget submissions
 - ◆ Links are included throughout the workbook to minimize data entry time and errors
- ◆ The provider agency is to check off the “Purpose” section on the right corner of the summary to identify why the budget is being prepared
 - ◆ Proposal – This should be checked on RFP submissions
 - ◆ Contract Budget – This should be checked for Contract award/renewal budget submissions
 - ◆ Fiscal Report – This should be checked off for monthly/quarterly reporting submissions
 - ◆ Also update Period Dates for the corresponding dates

Annex B: Contract Expense Summary

◆ Net Cost

◆ Net cost reflects the total cost of programs and equipment after revenue but before any profit

◆ Proposed Budget

◆ The total in this column should equal the total contract award

◆ Monthly or Quarterly Invoices

◆ The total in this column should equal the total amount requested for the reporting period

	A	B	C	D	E
1	(Revised October, 2002)				
2					
3	Provider Agency: AGENCY NAME				
4	Contract Number: CONTRACT NUMBER HERE				
5	Submission Date: DATE HERE				
6	Program Columns:	1	2	3	4
7	Budget Category	Grand	Subtotal	Subtotal	YYY
8	(See Schedules for Detail)	Total	Other	County	Grant Title
9				Contract	Program Name
10	A. Personnel Costs	0	0	0	0
11	B. Consultants & Professional Fees	0	0	0	0
12	C. Materials & Supplies	0	0	0	0
13	D. Facility Costs	0	0	0	0
14	E. Specific Aid to Clients	0	0	0	0
15	F. Other Expenses	0	0	0	0
16	G. Gen. & Admin. Dollar Allocation			0	
17	Gen. & Admin. Percent Dist.		#DIV/0!	#DIV/0!	#DIV/0!
18	H. Subtotal Operating Costs	0	0	0	0
19	I. Equipment Purchases	0	0	0	0
20	J. Total Costs	0	0	0	0
21	K. Provider Revenues	0	0	0	0
22	L. Net Cost	\$0	\$0	\$0	\$0
23	M. Service Units Provided		0		0
24	N. Agency Total Unit Cost		#DIV/0!		#DIV/0!
25	O. County Unit Cost		#DIV/0!		#DIV/0!
26					
27					
28					
29					

Annex B Supporting Schedules

- ◆ There are nine (9) supporting schedules
 - ◆ Personnel Cost Detail
 - ◆ Consultants and Professional Fees
 - ◆ Materials and Supplies
 - ◆ Facility Costs
 - ◆ Specific Financial Aid to Clients
 - ◆ Other Expenses (not covered in previous schedules)
 - ◆ Equipment Purchases
 - ◆ Provider Cost Share Revenues
 - ◆ Level of Service to be Provided (LOS)

Personnel Cost Detail

- ◆ Provides cost detail pertaining to salaries and wages and fringe benefits.
- ◆ The following information is to be completed by the provider agency
 - ◆ Staff Title and Name
 - ◆ Total Hours per Week Worked
 - ◆ Portion of Salary and Fringe Benefits to be covered

2							
3	Provider Agency: AGENCY NAME						
4	Contract Number: CONTRACT NUMBER HERE						
5	Submission Date: DATE HERE						
6	Program Columns:		1	2	3	4	
7		Total	Grand	Subtotal	Subtotal	YYYY	YY
8	Staff Title and Name	Hrs/Wk	Total	Other	County	Grant Title	Gran
9		Worked			Contract	Program Name	Progra
10	Salary Costs		0		0	0	
11			0		0		
12			0		0		
13			0		0		
14			0		0		
15			0		0		
16			0		0		
17			0		0		
18			0		0		
19			0		0		
20			0		0		
21			0		0		
22			0		0		
23			0		0		
24			0		0		
25			0		0		
26			0		0		
27			0		0		
28	Total Salary and Wage		0	0	0	0	
29	Fringe Benefits (at % of Salary)		0		0		
30	Total Personnel Costs (line A on Summary)		\$0	\$0	\$0	\$0	
31	Fringe Rate:						
32	Standard Work Week (in hrs.)						
33							

Consultants and Professional Fees

- ◆ These costs represent service agreements or fees for services rendered by professional organizations or by members of a profession who are not employees of the provider agency. These costs are for services such as medical, education, psychiatric/psychological, legal, accounting, employment, data processing, payroll preparation, and management services.
- ◆ Specify the service, rate and method of payment, and basis of allocation.

	A	B	C	D	E	F
1	(Revised October, 2002)					
2						
3	Provider Agency: AGENCY NAME					
4	Contract Number: CONTRACT NUMBER HERE					
5	Submission Date: DATE HERE					
6	Program Columns:	1	2	3	4	5
7	Name and Purpose	Grand	Subtotal	Subtotal	YYYY	YYYY
8	of Consultant or Professional Service	Total	Other	County	Grant Title	Grant Title
9	(Please indicate basis of fee charged)			Contract	Program Name	Program Name
10		0		0		
11		0		0		
12		0		0		
13		0		0		
14		0		0		
15		0		0		
16		0		0		
17		0		0		
18		0		0		
19		0		0		
20		0		0		
21		0		0		
22		0		0		
23		0		0		
24		0		0		
25		0		0		
26		0		0		
27		0		0		
28		0		0		
29	leave blank - new row marker	0		0		
30	Total Consult & Prof Fees (line B on Summary)	\$0	\$0	\$0	\$0	\$0
31						
32						
33						

Materials and Supplies

◆ Consumable Supplies

- ◆ Include the costs of materials and supplies necessary to carry out the objectives of the program.
- ◆ These may include medical, programmatic, vocational and recreational supplies. These types of costs should be identified specifically with a particular program.

◆ Food

- ◆ Food costs for staff and clients must be shown separately.
- ◆ Costs of food and beverages should be charged to provider agency activities (including unallowable and general and administrative activities) based on the number of meals served.
- ◆ Food costs should be adjusted to reflect all discounts, allowances, and income received from other funding sources, such as the Child Nutrition Program sponsored by the N.J. Department of Education

	A	B	C	D	E	F
1	(Revised October, 2002)					
2						
3	Provider Agency: AGENCY NAME					
4	Contract Number: CONTRACT NUMBER HERE					
5	Submission Date: DATE HERE					
6	Program Columns:	1	2	3	4	5
7	Consumable Materials	Grand	Subtotal	Subtotal	YYYY	YYYY
8	and Office Supplies	Total	Other	County	Grant Title	Grant Title
9				Contract	Program Name	Program Name
10		0		0		
11		0		0		
12		0		0		
13		0		0		
14		0		0		
15		0		0		
16		0		0		
17		0		0		
18		0		0		
19		0		0		
20		0		0		
21		0		0		
22		0		0		
23		0		0		
24		0		0		
25		0		0		
26		0		0		
27		0		0		
28		0		0		
29	[leave blank - new row marker]	0		0		
30	Total Supplies (line C on Summary)	\$0	\$0	\$0	\$0	\$0
31						
32						
33						

Facility Costs

◆ These costs represent all expenses associated with the usage and maintenance of buildings and equipment utilized by the provider agency

- ◆ Rental of Space
- ◆ Maintenance and Repair
- ◆ Utilities
- ◆ Insurance
- ◆ Other
 - ◆ Itemize the cost of any miscellaneous facility-related costs not listed above

	A	B	C	D	E	F
1	(Revised October, 2002)					
2						
3	Provider Agency: AGENCY NAME					
4	Contract Number: CONTRACT NUMBER HERE					
5	Submission Date: DATE HERE					
6	Program Columns:	1	2	3	4	5
7		Grand	Subtotal	Subtotal	YYYY	YYYY
8	Facility Cost Items	Total	Other	County	Grant Title	Grant Title
9				Contract	Program Name	Program Name P
10	Rent / Utilities	0		0	0	
11		0		0		
12		0		0		
13		0		0		
14		0		0		
15		0		0		
16		0		0		
17		0		0		
18		0		0		
19		0		0		
20		0		0		
21		0		0		
22		0		0		
23		0		0		
24		0		0		
25		0		0		
26		0		0		
27		0		0		
28		0		0		
29	[leave blank - new row marker]	0		0		
30	Total Facility Cost (line D on Summa	\$0	\$0	\$0	\$0	\$0
31						

Specific Financial Aid to Clients

- ◆ Included in this category is cash given to clients and expenditures made to purchase personal items for client use. These types of costs may be budgeted only if applicable to contract services and approved by the Passaic County DHS
 - ◆ **Allowances**
 - ◆ Amount of any allowance paid to each client
 - ◆ **Personal items**
 - ◆ Include health and beauty aids necessary to maintain clients' hygiene, clothing and personal appearance
 - ◆ **Other**
 - ◆ Itemize all other expenses associated with specific assistance to clients not covered above

	A	B	C	D	E	F
1	(Revised October, 2002)					
2						
3	Provider Agency: AGENCY NAME					
4	Contract Number: CONTRACT NUMBER HERE					
5	Submission Date: DATE HERE					
6	Program Columns:	1	2	3	4	5
7		Grand Total	Subtotal Other	Subtotal County Contract	YYYY Grant Title Program Name	YYYY Grant Title Program Name
8	Types of Assistance Provided					
9						
10		0		0		
11		0		0		
12		0		0		
13		0		0		
14		0		0		
15		0		0		
16		0		0		
17		0		0		
18		0		0		
19		0		0		
20		0		0		
21		0		0		
22		0		0		
23		0		0		
24		0		0		
25		0		0		
26		0		0		
27		0		0		
28		0		0		
29	[leave blank - new row marker]	0		0		
30	Total Client Aid (line E on Summary)	\$0	\$0	\$0	\$0	\$0
31						

Other Expenses

◆ Include in this category all other costs not covered in the previous categories. Some examples are:

◆ **Travel and Transportation**

◆ Transporting clients, staff travel, vehicle operating costs, rental costs etc

◆ **Training, Conferences and Meetings**

◆ Expenses for meetings and conferences relative to the agency's program activities

◆ **Dues and Subscriptions**

◆ Memberships and subscriptions to professional periodicals

◆ **Miscellaneous**

◆ Itemize all other costs not specifically provided for in the budget categories and subcategories above

	A	B	C	D	E	F
1	(Revised October, 2002)					
2						
3	Provider Agency: AGENCY NAME					
4	Contract Number: CONTRACT NUMBER HERE					
5	Submission Date: DATE HERE					(From A
6	Program Columns:	1	2	3	4	5
7	Expense Item	Grand	Subtotal	Subtotal	YYYY	YYYY
8	from Chart of Accounts	Total	Other	County	Grant Title	Grant Title
9				Contract	Program Name	Program Name
10		0		0		
11		0		0		
12		0		0		
13		0		0		
14		0		0		
15		0		0		
16		0		0		
17		0		0		
18		0		0		
19		0		0		
20		0		0		
21		0		0		
22		0		0		
23		0		0		
24		0		0		
25		0		0		
26		0		0		
27		0		0		
28		0		0		
29	[leave blank - new row marker]	0		0		
30	Total Other Exp (line F on Summary)	\$0	\$0	\$0	\$0	\$0
31						
32						
33						

Equipment Purchases

- On this schedule detail the purchase of equipment, i.e., items of nonexpendable tangible personal property having a useful life of more than 2 years and an acquisition cost of \$1,000 or more per unit.

	A	B	C	D	E	F
1	(Revised October, 2002)					
2						
3	Provider Agency: AGENCY NAME					
4	Contract Number: CONTRACT NUMBER HERE					
5	Submission Date: DATE HERE					
6	Program Columns:		1	2	3	4
7		Description of Use, Basis of Allocation and	Grand	Subtotal	Subtotal	YYYY
8	Equipment Purchased	and	Total	Other	County	Grant Title
9		Estimated Useful Life			Contract	Program Name Pr
10			0		0	
11			0		0	
12			0		0	
13			0		0	
14			0		0	
15			0		0	
16			0		0	
17			0		0	
18			0		0	
19			0		0	
20			0		0	
21			0		0	
22			0		0	
23			0		0	
24			0		0	
25			0		0	
26			0		0	
27			0		0	
28			0		0	
29	[leave blank - new row marker]		0		0	
30	Total Equip Purchase (line I on Summary)		\$0	\$0	\$0	\$0
31						

Revenue

- ◆ Itemize revenues, whether generated by providing services or contributed to the provider agency for the support of its budgeted costs, by program/activity

1	(Revised October, 2002)				
2					
3	Provider Agency: AGENCY NAME				
4	Contract Number: CONTRACT NUMBER HERE				
5	Submission Date: DATE HERE				
6	Program Columns:	1	2	3	4
7		Grand	Subtotal	Subtotal	YYYY
8	Revenue Sources and Descriptions	Total	Other	County	Grant Title
9				Contract	Program Name
10		0		0	
11		0		0	
12		0		0	
13		0		0	
14		0		0	
15		0		0	
16		0		0	
17		0		0	
18		0		0	
19		0		0	
20		0		0	
21		0		0	
22		0		0	
23		0		0	
24		0		0	
25		0		0	
26		0		0	
27		0		0	
28		0		0	
29	[leave blank - new row marker]	0		0	
30	Total Revenue (line K on Summary)	\$0	\$0	\$0	\$0
31					
32					
33					

Levels of Service to Be Provided

- ◆ On this schedule provide the following:
 - ◆ Case Movement (unduplicated)
 - ◆ Number of Family Groups, Individuals in Families and Individuals not in Families Served
 - ◆ Number of Service Units
- ◆ If this LOS does not fit the provider agency's services, they may provide a different report with their Annex B, as long as the same information is provided

1	(Revised October, 2002)							Passaic County Hum
2								
3	Provider Agency: AGENCY NAME						ANNEX B: CONTRACT	
4	Contract Number: CONTRACT NUMBER HERE						Schedule 9. Levels o	
5	Submission Date: DATE HERE							
6	Program Columns:							
7		1	2	3	4	5	6	7
8	Category and Level of Service	Grand Total	Subtotal Other	Subtotal County Contract	YYYY Grant Title	YYYY Grant Title	YYYY Grant Title	YYYY Grant Title
9					Program Name	Program Name	Program Name	Program Name
10	Case Movement (Unduplicated)							
11	Persons at Start of Period	0		0				
12	Persons Added/Transf. In	0		0				
13	Persons Terminated	0		0				
14	Persons at End of Period	0	0	0	0	0	0	0
15	Persons Served for Period	0	0	0	0	0	0	0
16								
17								
18	Number of Family Groups Served	0		0				
19	Number of Individuals in Families Served	0		0				
20	Number of Individuals Not in Families Served	0	0	0	0	0	0	0
21	Standard Service Units							
22	Meal Equivalents Provided	0		0				
23	Residence/Shelter Nights Provided	0		0				
24	Months Homeless Prevention Provided	0		0				
25	Telephone Contacts	0		0				
26	Face to Face Contacts with Clients	0		0				
27	Group Care Half Days Provided	0		0				
28	Personal Care Hours Provided	0		0				
29	Transportation Provided (One Way Trips)	0		0				
30								
31	Agency Defined Service Units							
32		0		0				
33		0		0				
34		0		0				
35		0		0				
36		0		0				

Reporting

- ◇ Reporting submissions are required for all contracts in order for payment to be issued.
- ◇ Programmatic & Fiscal Expenditure reports are due on a monthly or quarterly basis
 - ◇ Reports are due on the 15th of the month after the period closes
- ◇ Depending on the funding source, additional reporting requirements may be needed
 - ◇ Online Reporting Applications – HMIS, EmpowOR, JAMS
 - ◇ Detailed Level of Service Forms – required for State Addiction Contracts
- ◇ Reporting submissions are not cumulative – report only expenditures incurred within the relevant reporting period.



Questions

Passaic County Department of Human Services

401 Grand Street, Room 506

Contact Us

Paterson, NJ 07505

973-881-2834