# Attachment D: Budget Summary/Justification

**Name of Local Education Agency:** [NAME]

**Project:** School-Based Prevention Services – Multi-Tiered System of Supports

**Contract Dates:** July 1, 2024 – June 30, 2025

**A. Personnel:** *An employee of the agency whose work is tied to the proposal. Must include a minimum of one full-time employee who is considered the LEA’s School-Based Prevention Services Coordinator (or similar position title).*

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| --- | --- | --- | --- | --- |
| **Position** | **Name** | **Annual Salary/Rate** | **Level of Effort** | **Cost** |
| Prevention Services Coordinator |  |  | 100% |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  | **TOTAL** |  |

**Justification:** *Describe the role and responsibilities of each person.*

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**B. Fringe Benefits:** *List all components of fringe benefits rate.*

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| --- | --- | --- | --- |
| **Component** | **Rate** | **Wage** | **Cost** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  | **TOTAL** |  |

# Justification: *Describe the purpose of all components of fringe benefits.*

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**C. Travel:** *Explain the need for all travel. Must include travel to the ODMHSAS Momentum Conference and Children’s Behavioral Health Conference. Any and all out-of-state travel must be approved by the ODMHSAS.*

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| --- | --- | --- | --- | --- |
| **Purpose of Travel** | **Location** | **Item (Ex. Airfare, lodging, per diem, mileage)** | **Rate** | **Cost** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  | **TOTAL** |  |

**Justification:** *Describe the purpose of all travel and how costs were determined.*

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**D. Equipment:** *Item with a unit price of $500.00 or more and a usable life of one year or more.*

|  |  |  |
| --- | --- | --- |
| **Item(s)** | **Rate** | **Cost** |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **TOTAL** |  |

**Justification:** *Describe the purpose of equipment.*

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**E. Supplies:** *Materials costing less than $500 per unit and often having one-time use.*

|  |  |  |
| --- | --- | --- |
| **Item(s)** | **Rate** | **Cost** |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **TOTAL** |  |

**Justification:** *Describe need and include explanation of how costs were determined.*

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**F. Contractual:** *Expenses paid to non-employee for services or products. All subcontracts require prior approval.*

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| --- | --- | --- |
| **Entity** | **Product/Service** | **Cost** |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **TOTAL** |  |

**Justification:** *Describe the need of the contracted service.*

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**H. Other:** *Expenses not covered in any of the previous budget categories.*

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| --- | --- | --- |
| **Item(s)** | **Rate** | **Cost** |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **TOTAL** |  |

**Justification:** *Describe need and include explanation of how costs were determined.*

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|  |

# Indirect cost rate:

For Block Grant- *Indirect costs are limited to no more than 12.89% of total direct costs.*

# Budget Summary:

|  |  |
| --- | --- |
| **Category** | **Request** |
| Salaries & Wages | 0 |
| Fringe Benefits | 0 |
| Travel | 0 |
| Equipment | 0 |
| Supplies | 0 |
| Contractual | 0 |
| Other | 0 |
| Total Direct Costs | 0 |
| Indirect Costs | 0 |
| **Total Project****Costs** | **0** |