State of California
Department of Mental Health

IMD/RFA BUDGET

Health and Human Services Agency

FISCAL YEAR: _____

SUBMISSION DATE: _____

AGENCY: _____ TELEPHONE NUMBER: _____

CONTACT PERSON: _____ FAX NUMBER: _____

EMAIL: _____

	STAFFING		1	2	3
	TITLE OF POSITION	FTE	LAST APPROVED BUDGET	REQUEST OR CHANGE	TOTAL
1					$ -
2					$ -
3					$ -
4					$ -
5					$ -
6					$ -
7					$ -
8					$ -
9					$ -
10					$ -
11					$ -
12	**TOTAL STAFF EXPENSES (sum lines 1 thru 11)**		$ -	$ -	$ -
13	Consultant Costs (Itemize):				$ -
14					$ -
15					$ -
16					$ -
17	Equipment (Where feasible lease or rent) (Itemize):				$ -
18					$ -
19					$ -
20					$ -
21					$ -
22	Supplies (Itemize):				$ -
23					$ -
24					$ -
25					$ -
26					$ -
27					$ -
28	Travel -Per diem, Mileage, & Vehicle Rental/Lease				
29					$ -
30	Other Expenses (Itemize):				$ -
31					$ -
32					$ -
33					$ -
34					$ -
35					$ -
36					$ -
37	ADMINISTRATIVE COSTS				$ -
38	**NET PROGRAM EXPENSES (sum lines 12 thru 37)**		$ -	$ -	$ -

DMH APPROVAL BY: Cynthia Rutledge
TELEPHONE: (916) 654-2635
DATE: