



Sample - Operations Phase

School Based Health Center Program Application
Financial Information

Name of Lead Applicant Agency:	
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Section 1: Total CDPHE Funding Request

Did you receive a SBHC Program Planning Grant from CDPHE in FY2015-16 (anytime between July 1, 20** to June 30, 20**)? <i>Place a "X" in appropriate box</i>	Yes	No
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Section 2: Total Annual SBHC Operating Budget

The purpose of this form is to provide CDPHE with total cost details for operating the SBHC site(s), and all sources of support to cover all operating costs so there is no dependency on a single source. Mixed and balanced support is a requirement for sustainability and SBHC Program funding.

If requesting funds for more than one SBHC site, this total annual operating budget amount must reflect all costs for all sites combined. Applicant is solely responsible for ensuring all calculations are correct.	For the SBHC funding period of July 1, 20** - June 30, 20**
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Total Number of SBHC sites included in this total annual budget:	
Personal Services: Salaried Employees	
Personal Services: Hourly Employees	
Total Supplies, Equipment & Operating Expenses	\$
Travel	\$
Contractual <i>(for services provided by outside parties)</i>	\$
Other: <i>(specify)</i>	\$
Indirect	\$
Total Annual Operating Budget <i>(all costs for all SBHC sites combined)</i>	\$0.00
Total CDPHE Funding Requested <i>(from Attachment L: Budget and Justification Form. CDPHE amount requested for all SBHC sites combined for the funding period of 07/01/16 – 06/30/17)</i>	\$
Total Other Funding Sources <i>(As specified below under "Other Funding Sources." Line 25 must equal "Total Other Sources" below)</i>	\$

Note: Line 23 (all costs) must be covered by Lines 24 and 25.

Section 3: Other Funding Sources

	<i>Covering the period of July 1, 20** - June 30, 20**</i>	<i>Covering the period of July 1, 2016 - June 30, 20**</i>
(Add rows beneath each type of source as needed)	AMOUNT	PROJECTED AMOUNT

Public Insurance Revenue: (e.g. Medicaid, CHP+)	\$	\$
Private Insurance Revenue:	\$	\$
Patient fees / Self-Pay:	\$	\$
Donations:	\$	\$
Federal Funder: (list each funder's name below; add lines as needed)		
	\$	\$
	\$	\$
	\$	\$
	\$	\$
State Funder: (list each funder's name below; add lines as needed)		
	\$	\$
	\$	\$
	\$	\$
	\$	\$
Local Funder: (list each funder's name below; add lines as needed)		
	\$	\$
	\$	\$
	\$	\$
	\$	\$
Private/Foundation: (list each funder's name below; add lines as needed)		
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
In-Kind Support/Type of Support: (enter name[s] of in-kind source[s] and the type of support provided)		
	\$	\$
	\$	\$
	\$	\$
	\$	\$
Total Other Sources	\$0.00	\$0.00