NEW YORK STATE OFFICE OF ADDICTION SERVICES AND SUPPORTS
Supplemental Substance Abuse Prevention & Treatment Block Grant Initiative Funding Request
ATTACHMENT B - CONTRACT BUDGET AND FUNDING SUMMARY

1) **Initiative:** MOBILE MEDICATION UNITS (MMU) SUPP1012

County:

2) Printed Legal Name of Entity:	
3) SFS Supplier ID:	4) OASAS Provider Number:
5) Street Address/P.O. Box:	
6) City/Town/Village:	7) Postal Zip Code:
8) Printed Name of Contact Person:	9) Printed Title of Contact:
10) Contact Telephone #:	11) Contact E-Mail:

REQUESTED BUDGET (rounded to the nearest dollar)	**Amount**
12) Personal Services	
13) Fringe Benefits	
14) Other Than Personal Services/Non-Personal Services	
15) Equipment	
16) Property/Space	
17) Agency Administration (if applicable)	
TOTAL GROSS EXPENSE BUDGET	
Total Funds Requested	

18) Printed Name of Agency Official:	19) Printed Title:
20) Signature:	21) Date: