NYS Office of Addiction Services and Supports
Transitional Safety Units Operational Funding Request

1. Printed Legal Name of Applicant Entity:	
2. SFS Supplier ID:	3. OASAS Provider ID:
4. Provider's Street Address/P.O. Box:	
5. Provider's City/Town/Village:	6. Postal Zip Code:
7. Printed Name of Contact Person:	8. Printed Title of Contact:
9. Contact Telephone #:	10. Contact Email:

Date units expected to be operational:	
REQUESTED ANNUAL BUDGET (rounded to the nearest dollar)	**Amount** **ANNUAL OPERATING BUDGET**
11) Personal Services (1.0 FTE supportive staff)	
12) Fringe Benefits	
13) Other Than Personal Services/Non-Personal Services	
a) Furniture (maximum $3,000 per unit)	
b) Turnover expenses (maximum of 10% of annual rental subsidy budget)	
14) Equipment	
15) Property/Space	
a) Security Deposits	
b) Rental Subsidies	
16) Agency Administration	
TOTAL GROSS EXPENSE BUDGET	
Total Funding Requested	

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

Send completed budget form to the following email address: housing@oasas.ny.g

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 DETAIL

1) Initiative: Transitional Safety Units

2) Printed Legal Name of Entity:

Provider Name	Provider Number	County of Unit	Unit Type (Studio or 1-BR)	FMR	Anticipated Operational Date	Number of Units	Total Cost Request for Rent

BUDGET NARRATIVE

In the space below, please BRIEFLY:

- Demonstrate the need for these units in your community

- Illustrate your organizational readiness by presenting your plan to quickly establish leases and place tenants upon receiving funding