

**REQUEST FOR APPLICATION
OASAS PROJECT NO. SETT-23016**

ATTACHMENT 3 – PROGRAM BUDGET/INITIATIVE FUNDING REQUEST (IFR) FORM

PART I - PROVIDER INFORMATION

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

PART II – OPERATIONAL FUNDING REQUEST

1. Date Initiative expected to be operational:	
REQUESTED OPERATING BUDGET FOR PROPOSAL	ANNUAL OPERATING BUDGET
2. Gross Expense Budget (see instructions for details): Round Amounts to the nearest \$1 (no cents).	
Personal Services	
Fringe Benefits	
Non-Personal Services	
Equipment	
Property/Space	
Agency Administration (less than 20% of Personal Services, Fringe Benefits, and Non-Personal Services)	
TOTAL GROSS EXPENSE BUDGET	\$ 0
3. Revenue Budget (see instructions for details): Round Amounts to the nearest \$1 (no cents).	
Patient Fees	
SSI and SSA	
Public Assistance (Safety Net & TANF)	
Medicaid	
Medicaid Managed Care	
Medicare	
Third Party Insurance/Private Pay	
Food Stamps	
Closely Allied Entity Contributions	
Donations	
Other: Specify:	
Specify:	
Specify:	
TOTAL REVENUE BUDGET	\$ 0
4. NET OPERATING COST	
5. OASAS State Aid Funding Requested (this is the dollar amount that will be contracted for)	\$ 0
6. Full-Time Equivalent (FTE) Staff Requested:	
Applicant Official Printed Name:	Printed Title:
Signature:	Date:

**Instructions for Completing the Initiative Funding Request Form (IFR)
(Annual Operating Budget)**

PART I - PROVIDER INFORMATION

1. **Printed Legal Name of Bidder Entity** – Print the incorporated or legal name of the agency submitting the Initiative Funding Request on the IFR and on any additional pages that are attached. **Do not enter the common name or acronym.**
2. **Bidder's OASAS Provider Number** – Enter the unique 5-digit number that identifies the agency and that is used for reporting purposes to OASAS. This number is the same as the **Agency Code** number used when submitting Consolidated Fiscal Report (CFR) documents.
- 3-5. **Bidder's Address** – Enter the mailing address, including zip code, where the administrative office of the applicant entity is located.
6. **Date Prepared** – Enter the date the Initiative Funding Request Form (IFR) was prepared.
- 7-10. **Bidder Contact Person** – Enter the printed name and title, the telephone number (including area code), and email address of the person who can answer questions concerning the information provided on the IFR.

PART II – OPERATIONAL FUNDING REQUEST

1. **Date Program Expected to be Operational** – Enter the date, in the xx/xx/xxxx format, that the proposed initiative is expected to be operational and will require Aid to Localities funding from OASAS.

Requested Operating Budget for Proposal

Requested operating budget amounts must represent **12-month, full annual costs**, revenues, net deficit and OASAS State aid funding requested.

ALL AMOUNTS REQUESTED MUST BE ROUNDED TO THE NEAREST DOLLAR (\$1.00)

2. **Gross Expense Budget** – Applicants should refer to the Consolidated Fiscal Reporting (CFR) Manual for a more detailed general description of the following expense items:
 - Personal Services
 - Fringe Benefits
 - Non-Personal Services (i.e. Other than Personal Services (OTPS))
 - Equipment
 - Property/Space

➤ Agency Administration

3. **Revenue Budget** – Applicants should refer to the CFR Manual for an explanation of each revenue category, and enter applicable annual projected amounts that they anticipate receiving to offset costs attributable to the proposed program.

If the applicant does not anticipate receiving any revenue to offset costs of its proposal it should so indicate by entering \$0 for each category.

4. **Net Operating Cost** - Enter the amount obtained by subtracting **Total Revenue Budget** from **Total Gross Expense Budget**.
5. **OASAS State Aid Funding Requested** – Enter the amount of OASAS State aid funding being requested for this initiative. This amount **should equal** the **Operating Budget Net Deficit** amount.
6. **Full-Time Equivalent (FTE) Staff Requested** – Enter the number of FTE’s requested as part of this initiative.

Applicant Official

Enter the printed name and title of the applicant agency representative submitting the IFR proposal.

The IFR must be signed and dated by the applicant agency representative.