

MARYLAND DEVELOPMENTAL DISABILITIES COUNCIL

PROPOSED PROJECT BUDGET PACKAGE

A. Organizational Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____

Telephone: _____ Extension _____

Fax : _____

Email address: _____

Federal Employer I.D. Number _____ Minority Enterprise: _____

Period for which funds are requested: _____

RFP Number of Project to be Funded: _____

Title of Project to be Funded: _____

Area/Jurisdiction to be Served: _____

Type of Proposal: New _____ Renewal _____

Budget Summary: Council Share (Col. A) \$ _____ %

Local Match (Col. B + C) \$ _____ %

Total Project Cost (Col. D) \$ _____ %

B. Affirmation and Signature of Certifying Official

On behalf of the governing board or other executive authority of the above named organization, I affirm that the information and estimates conveyed in this proposed project budget are true and accurate to the best of my knowledge and that the local match will be contributed as proposed.

Signature: _____ Date: _____

Name: _____

Title: _____

PROPOSED PROJECT BUDGET

Project Number: _____ Date Submitted: _____

Contract Period: _____ Fiscal Year: _____

Organization: _____ Phone: _____

City/State/Zip: _____

Project Title: _____

Original Budget _____ Revised _____ Annual _____ Prorated _____

	Column A (Federal)	Column B (Non-Federal match)	Column C (Non-Federal match)	Column D
	DDC Funding Request	Supplemental Funding	In-Kind Funding	Total Project Budget
Salaries/Spec Pmts.				
Fringe				
Consultant				
Rent				
Utilities				
Telephone				
Postage				
Printing				
Transportation/Travel				
Insurance				
Legal/Accounting				
Audit				
Supplies				
Total Direct Costs				
Indirect Costs				
Total Costs				
Less Project Fees				
DDC Funding				

PROPOSED PROJECT BUDGET NARRATIVE

Line Item Name: _____
Explanation: _____

Line Item Name: _____
Explanation: _____

Line Item Name: _____
Explanation: _____

Line Item Name: _____
Explanation: _____

Line Item Name: _____
Explanation: _____

Line Item Name: _____
Explanation: _____

Line Item Name: _____
Explanation: _____

IF ADDITIONAL SPACE IS REQUIRED, PLEASE MAKE COPIES OF THIS FORM.

ANTICIPATED SOURCE OF FUNDING

SOURCES	AMOUNT
DDC Grant/Contract Award	
Other State Grant/Contract (Identify)	
Local Government (Identify)	
Direct Federal Grant (Identify)	
Medicaid Payment	
Insurance	
Fee Collections	
Private Fundraising/Donations	
United Way	
Total Cash (Must equal "Total Costs", Column A+ Column B)	
In-Kind - Identify (Must equal "Total Costs", Column C)	
Total (Column D)	

