MARYLAND DEPARTMENT OF HEALTH
FUNDING CERTIFICATION FORM
FUNDS CERTIFICATION FOR DELEGATED AND EXEMPT SOLICITATIONS AND CONTRACTS, GRANTS, AGREEMENTS, LOCAL HEALTH DEPARTMENTS OR INFORMATION TECHNOLOGY SERVICES AND SUPPLIES

1. Solicitation (IFB/RFP)	4. Modification/Amendment	7. BMO Log Number _____
2. Contract / MOU-MOA	5. Unified Grant Award	
3. Option Exercise	6. Grant	8. Contract Control Number _____

9. R*STARS FINANCIAL AGENCY NAME _____   13. DATE PREPARED:

10. R*STARS AGENCY CODE **M00** _____ APPROP CODE **32.** _____

11. EXPENDITURE CHARGED TO: PCA _____   AOBJ _____

12. FUNDING SOURCE - _____

14. DESCRIPTION OF SERVICE; AND PURPOSE: (Check one and enter description below)   Standard   Human   IT

15. REASON(S) WHY YOUR AGENCY OR ANOTHER STATE ENTITY ARE UNABLE TO PROVIDE REQUESTED SERVICES:

16. ANTICIPATED CONTRACT COST/VALUE	17. ESTIMATED ADDITIONAL COST TO STATE (Personnel, equipment, supplies, payroll, taxes, etc. <u>not</u> paid to this vendor.)
FY _____ \ _____ FY _____ \ _____ $ _____ FY _____ \ _____ TOTAL COST/VALUE FY _____ \ _____	

18. BIDDERS, EVEN IF ONLY ONE (Indicate selected vendor and check if MBE)	
A. _____ _____	19. SOLICIT. ISSUE DATE _____
B. _____ _____	20. CONTRACT START DATE _____
C. _____ _____	21. COMPLETION DATE _____
D. _____ _____	22. OPTION PERIOD(S) _____
E. _____ _____	23. PROCUREMENT METHOD _____
24. SELECTED VENDOR'S SSN/FEIN	25. CITY & STATE

26. *By my signature below, I certify that sufficient funds ____ have ____ have not been specifically provided in the budget for the services requested, and that the services are for State use. In either case, funds will be available from the following source(s):

PCA CODE	AOBJECT	FEDERAL GRANT TRACKING #	AMOUNT
a.			$ _____
b.			$ _____
c.			$ _____

	TITLE	NAME	SIGNATURE	PHONE	DATE
27.	REQUESTOR				
28.	AGENCY FISCAL OFFICER*				
29.	BMO BUDGET ANALYST*				
30.	PROCUREMENT OFFICER				