**FY2025 Oral Health Grants**

**Local Health Department Budget Narrative Template**

**[Insert Program Name]**

# Select One:\_\_\_ Component 1: Oral Disease and Injury Prevention

# \_\_\_ Component 2: Dental Sealants

# \_\_\_ Component 3: Oral Cancer Screenings / Dental Hygienist Funds (Previous Awardees Only)

# SALARIES/WAGES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Position Title and Name** | **Annual Salary** | **Time** | **Months** | **MDH****Amount Requested** | **Total Amount** |
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**TOTAL MDH SALARIES/WAGES AMOUNT REQUESTED $\_**

**Summary Justification:**

**FRINGE BENEFITS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Fringe Benefit** | **Percentage of Salary** | **MDH Amount Requested** | **Total Amount** |
| Retirement |  |  |  |
| FICA |  |  |  |
| Insurance |  |  |  |
| Workers Compensation |  |  |  |
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| --- | --- | --- | --- |
| **Fringe Benefit** | **Percentage of Salary** | **MDH Amount Requested** | **Total Amount** |
| Retirement |  |  |  |
| FICA |  |  |  |
| Insurance |  |  |  |
| Workers Compensation |  |  |  |
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| --- | --- | --- | --- |
| **Fringe Benefit** | **Percentage of Salary** | **MDH Amount Requested** | **Total Amount** |
| Retirement |  |  |  |
| FICA |  |  |  |
| Insurance |  |  |  |
| Workers Compensation |  |  |  |
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**TOTAL MDH FRINGE BENEFITS AMOUNT REQUESTED $**

**CONSULTANT COSTS**

1. Name of Consultant: Organizational Affiliation (if applicable):

Nature of Services to Be Rendered:

Relevance of Service to the Project:

Number of Days of Consultation (basis for fee):

Expected Rate of Compensation:

Method of Accountability:

1. Name of Consultant:

Organizational Affiliation (if applicable): Nature of Services to Be Rendered: Relevance of Service to the Project:

Number of Days of Consultation (basis for fee): Expected Rate of Compensation:

Method of Accountability:

1. Name of Consultant:

Organizational Affiliation (if applicable): Nature of Services to Be Rendered: Relevance of Service to the Project:

Number of Days of Consultation (basis for fee): Expected Rate of Compensation:

Method of Accountability:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Consultant** | **Organizational Affiliation** | **Expected Rate of Compensation** | **MDH Amount Requested** | **Total Amount** |
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# TOTAL MDH CONSULTANT COSTS REQUESTED $\_

**EQUIPMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item Requested** | **Number Needed** | **Unit Cost** | **MDH Amount Requested** | **Total Amount** |
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**TOTAL MDH EQUIPMENT REQUESTED $\_**

**Summary Justification:**

**SUPPLIES**

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| --- | --- | --- | --- |
| **Item Requested** | **Number Needed** | **MDH Amount Requested** | **Total Amount** |
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**TOTAL MDH SUPPLIES REQUESTED $\_**

**Summary Justification:**

**TRAVEL-In-State Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Number of Trips** | **Number of People** | **Number of Total Miles** | **Cost per Mile** | **MDH****Amount Requested** | **Total Amount** |
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**TOTAL MDH TRAVEL REQUESTED $\_**

**Summary Justification:**

**OTHER**

|  |  |  |  |
| --- | --- | --- | --- |
| **Item Requested** | **Number Needed** | **MDH Amount Requested** | **Total Amount** |
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**TOTAL MDH OTHER REQUESTED $\_**

**Summary Justification:**

**CONTRACTUAL COSTS**

1. Name of Contractor: Method of Selection:

Period of Performance:

Scope of Work:

Method of Accountability:

Itemized Budget and Justification:

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1. Name of Contractor: Method of Selection:

Period of Performance:

Scope of Work:

Method of Accountability:

Itemized Budget and Justification:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Name of Contractor: Method of Selection:

Period of Performance:

Scope of Work:

Method of Accountability:

Itemized Budget and Justification:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Contractual Items** | **Name of Organization** | **MDH Amount Requested** | **Total Amount** |
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# TOTAL MDH CONTRACTUAL COSTS REQUESTED $

**MDH COSTS REQUESTED**

**MDH SALARIES/WAGES REQUESTED $**

**MDH FRINGE BENEFITS REQUESTED $\_ MDH CONSULTANT COSTS REQUESTED $\_ MDH EQUIPMENT REQUESTED $\_**

**MDH SUPPLIES REQUESTED $\_**

**MDH TRAVEL REQUESTED $**

**MDH OTHER REQUESTED $ MDH CONTRACTUAL COSTS REQUESTED $**

**TOTAL MDH DIRECT COSTS REQUESTED $**

**TOTAL MDH INDIRECT COSTS REQUESTED (Max. 10% of Total Direct Costs) $ \_\_\_\_\_\_\_\_\_**

**TOTAL MDH DIRECT AND INDIRECT COSTS REQUESTED $**