OKLAHOMA STATE DEPARTMENT OF HEALTH
CONTRACT BUDGET FORM

Contractor: _____ Date: _____

Contractor Contact:_____ Phone: _____

Contractor Address: _____

Dollar Amount: $_____

Summary Budget Request:

Budget Line Item	OSDH Amount	Match (if applicable)	TOTAL
Personnel/Salaries			
Fringe Benefits			
Travel/Training			
Supplies			
Contractual			
Admin Costs/IDC			
Other			
Total			

**** Local Match Funding source(s):** _____

_____

Narrative/Detail Budget Request:

Personnel/Salaries							
Position Title	**Staff Name**	**Annual Salary**	**No. Months**	**% Time**	**STATE**	**MATCH (if applicable)**	**TOTAL**
Category Total							

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Contractor Name: _____ Date: _____

Narrative/Detail Budget Request (Continued):

Fringe Benefits	**STATE**	**MATCH (if applicable)**	**TOTAL**
Category Totals			
Travel-PerDiem/Training	**STATE**	**MATCH (if applicable)**	**TOTAL**
Category Totals			
Supplies	**STATE**	**MATCH (if applicable)**	**TOTAL**
Category Totals			
Contractual	**STATE**	**MATCH (if applicable)**	**TOTAL**
Category Totals			
Admin Costs/IDC	**STATE**	**MATCH (if applicable)**	**TOTAL**
Category Totals			
Other	**STATE**	**MATCH (if applicable)**	**TOTAL**
Category Totals			
	STATE	**MATCH (if applicable)**	**TOTAL**
Category Totals			
TOTAL PROGRAM COSTS			

Contractor's Signature: _____ Date: _____

Printed Name: _____ Title: _____