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| LHD or Tribe Name: | | | | | | | | | | | | | | | | Date submitted: | | | |
| Name of person submitting: | | | | | | | | | | | | | | | | | | | |
| **PLEASE COMPLETE THE APPROPRIATE SECTIONS BELOW.**  *(If more space is needed, please submit as many pages as necessary.)* | | | | | | | | | | | | | | | | | | | |
| *PERSONNEL* | | | | | | | | | | | | | | | | | | | |
| **Employee’s Name, Position Title** | | | | | | | | **Annual Salary** | | | | | **% Effort for COVID-19** | | | **Amount Requested** | | | |
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| *FRINGE BENEFITS* | | | | | | | | | | | | | | | | | | | |
| **Employee’s Name, Position Title** | | | | | | | **Rate of Fringe Benefits** | | | | | | | | **Fringe Total** | | | | |
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| *CONSULTANT COSTS* | | | | | | | | | | | | | | | | | | | |
| **Name of Consultant** | | | |  | | | | | | | | | | | | | | | |
| **Organizational Affiliation** | | | |  | | | | | | | | | | | | | | | |
| **Nature of Service to be Rendered** | | | |  | | | | | | | | | | | | | | | |
| **Relevance of Service to the Project** | | | |  | | | | | | | | | | | | | | | |
| **Number of Days/Hours of Consultation (Basis for Fee)** | | | |  | | | | | | | | | | | | | | | |
| **Expected Rate of Compensation** | | | |  | | | | | | | | | | | | | | | |
| **Method of Accountability** | | | |  | | | | | | | | | | | | | | | |
| *EQUIPMENT* | | | | | | | | | | | | | | | | | | | |
| **Item Requested & Description** | | | **Who’s Using It** | | | **Quantity** | | | | **Unit Cost** | | | | | | | **Amount** | | |
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| *SUPPLIES* | | | | | | | | | | | | | | | | | | | |
| **Supplies** | | | | | | | | **Number Needed** | | | **Unit Cost** | | | | | | | **Total** | |
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| *IN-STATE TRAVEL* | | | | | | | | | | | | | | | | | | | |
| **In-State Travel Purpose** | **Number of Trips** | **Number of Employee(s) & their position title(s)** | | | **Approximate Dates of Travel** | | | | **Total Number of Miles** | | | **Cost per mile** | | **Per Diem** | | **Lodging Cost** | | | **Total Expense per item** |
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| *OTHER* | | |
| **Item** | **Details** | **Total** |
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| *CONTRACTUAL COSTS* | | | |
| **Name of Contractor** |  | | |
| **Method of Selection** |  | | |
| **Period of Performance** |  | | |
| **Scope of Work** |  | | |
| **Method of Accountability** |  | | |
| **Itemized Budget and Justification** |  | | |
| *INDIRECT COSTS* | | | |
| **Indirect Costs** | **Methodology** | | **$0** |
|  |  | |  |
| KDHE use below | | | |
| Reviewed by: | Approval date: | Received finalized expenditure report: | |