Fallbrook Regional HEALTH DISTRICT

AGENDA
STRATEGIC PLANNING COMMITTEE

Wednesday, January 20, 2021 at 5:00 P.M.

In accordance with the current State of Emergency and the Governor's Executive Order N-25-20, of March 12, 2020 and N-33-20 of March 19, 2020, teleconferencing will be used for this meeting. Board members, staff and members of the public will be able to participate by webinar by using the following link: https://us02web.zoom.us/j/89674799373
Meeting ID: 896 7479 9373. Participants will need to download the Zoom app on their mobile device. Members of the public will also be able to participate by telephone using the following dial in information: Dial in #: (310) 372-7549 Passcode 660448.

Committee Members: Jennifer Jeffries, Chair and Howard Salmon, Co-chair
CEO: Rachel Mason
Staff Members: Linda Bannerman, Pam Knox and Mireya Banuelos

1. Call to Order/Roll Call
2. Public Comments
3. Discussion Items
   a. Review Draft Grant Application FY 2021-2022
4. Board Member Comments and Future Agenda Items
5. Adjournment

I certify that on January 19, 2021, I posted a copy of the foregoing agenda near the regular meeting place of the Board of Directors of Fallbrook Regional Health District, said time being at least 24 hours in advance of the meeting. The American with Disabilities Act provides that no qualified individual with a disability shall be excluded from participation in or denied the benefits of District business. If you need assistance to participate in this meeting, please contact the District office 24 hours prior to the meeting at 760-731-9187.

Linda Bannerman

Board Secretary/Clerk

EDIT WELCOME PAGE

Eligibity Check

Please refer to the eligibility guidelines on our website (https://www.fallbrookhealth.org/community-health-contract-grants) before proceeding to the next section.

1 Question

NEXT →

Tax Exempt Status *

Is your organization a 501c(3) tax exempt?

YES

NO - Contact District staff.

Please contact District staff to determine eligibility.

Applicants must be tax-exempt, 501(c)3, or a specially invited entity to qualify for Community Health Contract grant funding. No less than 80% of the recipients must reside within the communities of Bonsall, De Luz, Fallbrook or Rainbow. For more information please contact our office at 760.731.9187 and ask for the CEO or Community Health Coordinator.

3 Questions

← PREVIOUS

NEXT →

What is your EIN/Tax Exempt 501(c)3 designation ID# *

Do not include the dash.

Service Area *

What area(s) will this program serve (check all that apply).

- [ ] Bonsall
- [ ] De Luz
- [ ] Fallbrook
- [ ] Rainbow
- [ ] None of these areas - not eligible for consideration

Will no less than 80% of the program recipients live within the communities of Fallbrook, Rainbow, Bonsall or De Luz? *

Type a description

YES

NO - not eligible for consideration

Ineligible - Contact the District

Community Health Contract Grants are only available for programs where at least 80% of the service recipients reside within the communities of Bonsall, De Luz, Fallbrook and/or Rainbow.

0 Question

← PREVIOUS

NEXT →

Organization Information

For collaborative submissions please apply under the primary fiscal agent.

16 Questions

← PREVIOUS NEXT →

Organization Name

Please provide the legal name of the organization, as it appears on your 990. If you have a different DBA or nickname please add that in the box after the legal name.

Legal Name:

DBA:

Collaborative/Joint Application *

Is this application being submitted in collaboration with another agency?

YES NO

Collaborative Organization Name

This question is ONLY for submissions being applied for by two or more agencies. The primary applicant will serve as the fiscal agent and all other questions will refer to the primary applicant.. Please provide the legal name of the collaborating organization, as it appears on the 990. If you have a different DBA or nickname please add that in the box after the legal name.

Legal Name:

DBA:

Year the Organization was founded. *

The year incorporated.

Organization Contact *

Please list the name of the person who is responsible for the submission and management of this proposal.

First Name

Last Name

Contact Email *

Please provide the email address for the person responsible for the submission and management of this proposal.

example@example.com

Organization Phone Number *

Type a description

Area Code

Phone Number

Organization Mailing Address *

This addressed will be used for all mailing purposes.

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Organization Physical Address *

This is the primary address where the Organization provides services.

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Board of Directors *

Please upload a list of your Board of Directors, include Full Name - First, Last, Board Position, Professional Affiliation/Industry.

Drag and drop files here

Max. file size: 10.6MB

BROWSE FILES

Financial Documents *

Most recent audited financials with management letter – if your agency does not have audited financials please include the most recent Fiscal year end P&L and Balance Sheet.

Drag and drop files here
Max. file size: 10.6MB

BROWSE FILES

Financial Documents *

Most recent Fiscal year end P&L and Balance Sheet.

Drag and drop files here
Max. file size: 10.6MB

BROWSE FILES

Financial Documents *

Most recent 990

Drag and drop files here
Max. file size: 10.6MB

BROWSE FILES

Organization’s Mission Statement *

Type a description

Agency Capability *

Briefly describe your organization's history and accomplishments.

Agency Collaborations *

List and describe current collaborations with other organizations that enhance your ability to provide services through this program.

Program Information

This section will ask for you to describe the program or service intervention for which you are seeking funding support.

14 Questions

← PREVIOUS NEXT →

Program Information - Type *

Is this program time bound or ongoing?

- ◯ Time Bound
- ◯ Ongoing

Type a question

Please select the start and end dates for this program.

January 2021

Mo	Tu	We	Th	Fr	Sa	Su
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Please select the start and end dates for this program.

Target Population - Age *

List the percentages of your program participants' ages. Percentages must add up to 100%

	Percent of program participants
Children (infants to 12)	
Young Adults (13-18)	
Adults (18-60)	
Seniors (60+)	
We do not collect this data (indicate with 100%)*	

Target Population not collected - Age

If you indicated that you do not collect data on the above question, please provide a rationale as to why that information is not sought. Write NA if this question does not apply to your organization

Gender *

List the percentages of your program participants' gender identification. Percentages must add up to 100%

	Percent of program participants
Female	
Male	
Non-binary	
Unknown*	

*Target Population - Gender

If you indicated that you do not collect data on the above question, please provide a rationale as to why that information is not sought. Write NA if this question does not apply to your organization

Income Level *

List the percentages of your program participants' income limit category - 2019 HUD – AMI Income limits (4 person family). Percentages must add up to 100%

	Percent of program participants
Extremely Low-Income Limits, ceiling of $32,100	
Very Low (50%) Income Limits, ceiling of $53,500	
Low (80%) Income Limits, ceiling of $85,600	
Higher Than Listed Limits	
We do not collect this data (indicate with 100%)*	

*Target Population - Income Level

If you indicated that you do not collect data on the above question, please provide a rationale as to why that information is not sought. Write NA if this question does not apply to your organization

Projected number of residents that will directly benefit (participant/client) from this program. *

The number of residents that receive the service or who are enrolled in your program.

ex: 23

Explanation - Directly benefiting *

Please explain how you calculate the number of residents who receive this direct service or benefit.

Projected number of residents that will indirectly benefit (participant/client) from this program. *

The number of residents that receive some benefit from being related to, living with or otherwise being in contact with the direct program beneficiary.

ex: 23

Explanation - Indirectly benefitting *

Please explain how you calculate the number of residents who receive this indirect benefit. *Example - 1 student with an average of 3 additional family members. Therefore, 20 students would average an indirect benefit of 60 individuals who received some benefit from eth students' participation in the program.*

Statement of Need/Problem *

Discuss the need for the proposed program or service within the District. The need you address must clearly relate to your organization's mission and purpose. It should focus on the people you serve, not your organization's needs, and it should be well supported by evidence such as statistics, and trends within your service sector. Include qualitative and quantitative data that support your argument as well as relevant statistics and research. You may use the link option to point to pertinent online resources.

Statement of Need/Problem - Others *

What other organizations within the community offer similar programs/services that address this need?

Social Determinants of Health (SDOH)

The Fallbrook Regional Health District has identified several Social Determinants of Health that demonstrate a significant impact on the long term health and well being of our community. The following questions address how your program and/or services address these concerns.

16 Questions

← PREVIOUS NEXT →

Program/Services Description *

Which one of the following categories best describes the primary goal and objectives of your program?

- Prevention/Education: Supplies/training of health practices or to prevent/control of disease/injury.
- Treatment: Direct provision of care in medical, dental, vision, or behavioral health.
- Ancillary: Services that align with the District's mission to assist residents to lead healthy lives, supporting a greater life span and independence.

Program/Services Description - Social Determinants of Health *

Please select which of the following SDOH your program addresses.

- [ ] Economic Stability (Employment, Food Insecurity, Housing Instability, Poverty)
- [ ] Education Access & Quality (Early Childhood Education and Development, Enrollment in Higher Education, High School Graduation, Language and Literacy)
- [ ] Social & Community Context (Civic Participation, Discrimination, Incarceration, Social Cohesion)
- [ ] Healthcare Access & Quality (Access to Health Care, Access to Primary Care, Health Literacy)
- [ ] Neighborhood & Built Environment (Access to Foods that Support Healthy Eating Patterns, Crime and Violence, Environmental Conditions, Quality of Housing)

Program/Services Description - Program Entry *

Concisely outline how recipients enter the program. How are participants enrolled or connected to the program?

Program/Services Description - Program Activities *

Describe or define what interventions or services they receive. What does the service/program do to assist the participant. How is this service/program helpful.

Program/Services Description - Follow Up *

What follow up, if any, is provided to the participant post intervention/service? If no follow up services are offered please explain how the impact of the intervention is determined.

Program Goal #1 *

What is the program goal? Be clear in defining how the goal(s) relate to how the program addresses the need.

Program Objectives - Goal #1 *

What is/are the program objectives for the goal 1. Please add a text box for each of the objectives defined. Be clear in defining how each objective serves the goal. Keep in mind that your objectives should be Specific: provides the “who” and “what” of program activities. Measurable: focus on “how much” change is expected, should quantify the amount of change expected. Achievable: can be either implied or explicit; however, it should be attainable within a given time frame and with available program resources. Realistic: most useful when they accurately address the scope of the problem and programmatic steps that can be implemented within a specific time frame. and Time-phased: provide a time frame indicating when the objective will be measured or a time by which the objective will be met.

ADD BOX FOR ADDITIONAL OBJECTIVE

Program Outcomes/Measurables - Goal & Objectives #1 *

Explain how you measure the success of the program’s interventions or services for each objective. Define the measurable activities and outcomes the program generates for each objective stated above. What quantitative information will you be gathering and reporting as it relates to the impact of your program's services.

Additional Program Goals *

Are there additional Goals for this program?

YES

NO

Program Goal #2

What is the program goal? Be clear in defining how the goal(s) relate to how the program addresses the need.

Program Objectives - Goal #2

What is/are the program objectives for goal 2. Please add a text box for each of the objectives defined. Be clear in defining how each objective serves the goal. Keep in mind that your objectives should be Specific: provides the “who” and “what” of program activities. Measurable: focus on “how much” change is expected, should quantify the amount of change expected. Achievable: can be either implied or explicit; however, it should be attainable within a given time frame and with available program resources. Realistic: most useful when they accurately address the scope of the problem and programmatic steps that can be implemented within a specific time frame. and Time-phased: provide a time frame indicating when the objective will be measured or a time by which the objective will be met.

ADD BOX FOR ADDITIONAL OBJECTIVE

Program Outcomes/Measurables - Goal & Objectives #2

Explain how you measure the success of the program's interventions or services for each objective. Define the measurable activities and outcomes the program generates for each objective stated above. What quantitative information will you be gathering and reporting as it relates to the impact of your program's services.

Additional Program Goals

Is there and additional Goal for this program? Only three Goals are allowed in this application.

YES

NO

Program Goal #3

What is the program goal? Be clear in defining how the goal(s) relate to how the program addresses the need.

Program Objectives - Goal #3

What is/are the program objectives for goal 3. Please add a text box for each of the objectives defined. Be clear in defining how each objective serves the goal. Keep in mind that your objectives should be Specific: provides the “who” and “what” of program activities. Measurable: focus on “how much” change is expected, should quantify the amount of change expected. Achievable: can be either implied or explicit; however, it should be attainable within a given time frame and with available program resources. Realistic: most useful when they accurately address the scope of the problem and programmatic steps that can be implemented within a specific time frame. and Time-phased: provide a time frame indicating when the objective will be measured or a time by which the objective will be met.

ADD BOX FOR ADDITIONAL OBJECTIVE

Program Outcomes/Measurables - Goal & Objectives #3

Explain how you measure the success of the program’s interventions or services for each objective. Define the measurable activities and outcomes the program generates for each objective stated above. What quantitative information will you be gathering and reporting as it relates to the impact of your program's services.

Anticipated Acknowledgment

Please describe how the Fallbrook Regional Health District’s investment in this program will be acknowledged. This includes all print and electronic materials, press releases, website references, and any other form of written and verbal publicity that relates to the funded program.

2 Questions

Anticipated Acknowledgment *

Please select the methods by which the Organization will acknowledge the District's investment of funding.

- [ ] Social Media Postings
- [ ] Signage at Service Sites
- [ ] Print Materials to Service Recipients
- [ ] Website Display
- [ ] Other

Anticipated Acknowledgment *

Please explain how the District's name or logo will be promoted. If selected, please identify which social media platforms your organization utilizes.

Financial Reporting & Budget

Type a subheader

7 Questions

← PREVIOUS NEXT →

Funding History *

Has the organization requested funding from FRHD for this program before?

- ◯ Yes, requested and funded
- ◯ Yes, requested but not funded
- ◯ Have not applied before

Funding History *

Have grant funds awarded to your organization ever been withdrawn, reduced or discontinued?

YES NO

Funding History - withdrawn, reduced or discontinued explained

Please explain why funding was withdrawn, reduced or discontinued.

Funding History *

List other grant funders that have been approached by your organization for this program in the past year, do not include FRHD. Include Name, Date, Amount Requested, Declined or Pending.

Drag and drop files here
Max. file size: 10.6MB

BROWSE FILES

Program Budget *

Please upload your program Budget and Narrative file. Use the District provided spreadsheet which can be found here https://www.fallbrookhealth.org/community-health-contract-grants.

Drag and drop files here
Max. file size: 10.6MB

BROWSE FILES

Terms and Conditions *

Checking this box certifies that all information presented in or attached to this Application is complete and accurate.

☐ Rights Reserved by the Board of Directors - found online at https://www.fallbrookhealth.org/community-health-contracts-grants-policy-procedures *

Authorized Signature *

Please sign the application

SUBMIT

EDIT THANK YOU PAGE

Fallbrook Regional HEALTH DISTRICT

FRHD CHC GRANT BUDGET INSTRUCTIONS

This file has a number of pre-formated pages. Those sections for auto calculations and set formats are shaded in grey and should not be altered. Please keep a copy of this document as it will be used as part of the grant reporting process

There are five tabs to this file:

1. **Instructions**
2. **Program Budget Form**
3. **Revenue Sources**
4. **Budget Narrative**
5. **Budget Reporting Form**

1 Instructions:

> All Yellow sections are to be filled out by the applicant. Grey sections will auto calculate and should not be edited by the applicant. All pages are formatted to print portrait, on 1

2 Program Budget Form:

> PROGRAM COST: This section should reflect the true and total costs of the program.

> APPLYING ORGANIZATION: This is the applicant agency's investment in their program. This is the value of the resources the agency will contribute to the program's cost. These may include funds from fundrasaing events, private donors, in-kind goods and services, and volunteer efforts.

> OTHER RESOURCES: These are funds or resources provided from contracts, grants and partnerships that are used to support the program's operations.

> REQUESTED FROM FRHD: This is the funding request you are putting forward to the District.

> The line item names may not fully align with your budget. Please edit those items to align with your budget. Explain those items on your Budget Narrative Form as necessary.

A INDIRECT EXPENSES:
This section is for expenses that are part of indirect operats of the program, necessary which may not be part of the direct service provision expenses (Adminsitration, facility expenses, general liability ins., etc.). Please refer back to the training materials for clarification of these expenses. The District will not consider funding more than 25% of these expenses

B PERSONNEL EXPENSES - PROGRAM SPECIFIC:
As stated, this section is for staffing expenses that are directly related to the provision of the services/program. Please list each position title separately, unless there are multiple of the same title then use (x3) as an indicator. For example, if funding salaries for four separate Drivers, you would indicate as, Driver (x4) and the expense amount would be the cost of all four Drivers. Please include a single line items for general staffing expenses such as personell expenses (Payroll taxes, WC, etc). Benefits (health, retirement, etc) shoud be listed on a separate line.

Fallbrook Regional HEALTH DISTRICT

C DIRECT PROGRAM EXPENSES:

This section is for supplies, items and or specific expenses related to the provision of the services/program. This may include phone, rent, prining, program related insurance (e.g., vehicle), trainings and cetifications.

3 Revenue Sources

> Please list all sources of revenue the agency recieves by category. This Form has two sections, one for Agency Funding and one for Project Funding. Please fill out both sides of the table. Amounts do not need to be exact; however, we ask for best estimates.

4 Budget Narrative

> There are headers that align with the Budget Form. These items should be explained (narrative) if they are unsusual or have a specific project impact. Explanations regarding utliity expenses are generally understood, but expenses relating to trianing or for a specilayty insurance could be expressed here.

5 Budget Reporting Form

> This form will be used for those grantees who are awarded contracts. This form would be submitted with the quarterly Impact Report and should demonstrate that funds were allocated according to the submitted proposal budget.

Fallbrook Regional HEALTH DISTRICT

FRHD CHC GRANT BUDGET FORM

Agency Name:		PROGRAM NAME:	

Not all line items will correspond with your program budget. If the item does not fully align either leave it blank or group it in the best category possible. However, be sure your program budget is fully itemized.

1)

	A	INDIRECT EXPENSES:	PROGRAM COST	APPLYING ORGANIZATION	OTHER RESOURCES	REQUESTED FROM FRHD
	A1	*Administrative Support*				
	A2	*General Insurance (not program specific)*				
	A3	*Accounting & audit expenses*				
	A4	*Consultant/Contractor Fees*				
	A5	*Physical Assets (Rent, Facility Costs)*				
	A6	*Utilities*				
	A7	*IT & Internet*				
	A8	*Marketing & Communications*				
	A9	*Office Supplies*				
	A10	*Training & Education*				
	A11	*Other: specify*				
		TOTAL INDIRECT EXPENSE	-	-	-	-
	B	**PERSONNEL EXPENSES - PROGRAM SPECIFIC**	PROGRAM COST	APPLYING ORGANIZATION	OTHER RESOURCES	REQUESTED FROM FRHD
	B1	*Salary (list position)*				
	B2	*Salary (list position)*				
	B3	*Salary (list position)*				
	B4	*Salary (list position)*				
	B5	*Payroll Expenses (WC, taxes)*				
	B6	*Benefits*				
	B7	*Other: specify*				
		TOTAL PERSONNEL EXPENSE	-	-	-	-
	C	**DIRECT PROGRAM EXPENSES**	PROGRAM COST	APPLYING ORGANIZATION	OTHER RESOURCES	REQUESTED FROM FRHD
	C1	*Equipment*				
	C2	*Program/Project Supplies*				
	C3	*Printing/Duplicating*				
	C4	*Travel/Mileage*				
	C5	*Program Specific Insurance*				
	C6					
	C7					
	C8					
	C9					
	C10					
	C11					
	C12					
	C13					
	C14					
	C15					
		TOTAL OTHER EXPENSES	-	-	-	-
			W	X	Y	Z

D	TOTAL ALL EXPENSES	PROGRAM COST	% REQUESTED FROM FRHD
		$ -	#DIV/0!

2) FUNDING SOURCES

E	FUNDS FOR PROGRAM		
E1	APPLYING ORGANIZATION	X	-
E2	OTHER RESOURCES	Y	-
E3	REQUESTED FROM FRHD	Z	-
	TOTAL ALL FUNDING SOURCES	W	$ -

NOTE: THIS AMOUNT SHOULD BE EQUAL TO YOUR PROJECT COST.

3) % OF AGENCY BUDGET

F				
	CALCULATE % of Total Agency budget that this Program represents.		$ -	#DIV/0!
		AGENCY BUDGET**	PROGRAM COST	% of AGENCY BUDGET

** Agency budget is your agency's entire budget for the year. Fill in the amount.

Fallbrook Regional HEALTH DISTRICT

Agency Name:	**0**
Program Name:	**0**
Total Organization Budget (Current Fiscal Year)	$ -
Total Project Budget (Current Fiscal Year)	$ -

	Organization Sources of Revenue *(Total Organization Budget)*			**Sources of Funding** *(This Project Request)*		
Source of funds	$ Amount	Percent of Total	One-time funding? (Yes/No)	$ Amount	Percent of Total	One-time funding? (Yes/No)
Federal						
State						
City/County*						
Other Govt.						
Proposed FRHD						
Fees for Service						
Grants (non-gov't)						
General Donations						
Other Internal Organizational Fundraising						
Other (list):						
Total	$0.00	0%		$0.00	0%	

* City/County

If the organization currently receives funding from any Cities or Counties, please list the jurisdiction and contract amount below.

Fallbrook Regional HEALTH DISTRICT

Agency Name: 0

Program Name: 0

INSTRUCTIONS:

1 List items from your PROJECT BUDGET FORM (Sections A and B) where an expense is indicated, that you are seeking FRHD support.

2 Provide a brief narrative description of each budget line item to be funded by the proposed grant.

3 Your narrative should explain why this expense is necessary to the project and why or how FRHD funding would make an impact.

A. INDIRECT EXPENSES: Please indicate by the Line Number and Item Name

#	Name	Narrative:

B. PERSONNEL EXPENSES -PROGRAM SPECIFIC

#	Name	Narrative:

C. DIRECT PROGRAM EXPENSES

#	Name	Narrative:

Fallbrook Regional HEALTH DISTRICT

FRHD CHC GRANT BUDGET REPORTING FORM

Agency Name: 0 **PROGRAM NAME:** 0

Not all line items will correspond with your program budget. If the item does not fully align either leave it blank or group it in the best category possible. However, be sure your program budget is fully itemized.

1)

	A	INDIRECT EXPENSES:	PROGRAM COST	REQUESTED FROM FRHD	*AMOUNT USED Q1*	*AMOUNT USED Q2*	*AMOUNT USED Q3*	*AMOUNT USED Q4*
	A1	*Administrative Support*	$ -	$ -				
	A2	*General Insurance (not program specific)*	$ -	$ -				
	A3	*Accounting & audit expenses*	$ -	$ -				
	A4	*Consultant/Contractor Fees*	$ -	$ -				
	A5	*Physical Assets (Rent, Facility Costs)*	$ -	$ -				
	A6	*Utilities*	$ -	$ -				
	A7	*IT & Internet*	$ -	$ -				
	A8	*Marketing & Communications*	$ -	$ -				
	A9	*Office Supplies*	$ -	$ -				
	A10	*Training & Education*	$ -	$ -				
	A11	*Other: specify*	$ -	$ -				
		TOTAL INDIRECT EXPENSE	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
	B	**PERSONNEL EXPENSES - PROGRAM SPECIFIC**	PROGRAM COST	REQUESTED FROM FRHD	*AMOUNT USED Q1*	*AMOUNT USED Q2*	*AMOUNT USED Q3*	*AMOUNT USED Q4*
	B1	*Salary (list position)*	$ -	$ -				
	B2	*Salary (list position)*	$ -	$ -				
	B3	*Salary (list position)*	$ -	$ -				
	B4	*Salary (list position)*	$ -	$ -				
	B5	*Payroll Expenses (WC, taxes)*	$ -	$ -				
	B6	*Benefits*	$ -	$ -				
	B7	*Other: specify*	$ -	$ -				
		TOTAL PERSONNEL EXPENSE	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
	C	**DIRECT PROGRAM EXPENSES**	PROGRAM COST	REQUESTED FROM FRHD	*AMOUNT USED Q1*	*AMOUNT USED Q2*	*AMOUNT USED Q3*	*AMOUNT USED Q4*
	C1	*Equipment*	$ -	$ -				
	C2	*Program/Project Supplies*	$ -	$ -				
	C3	*Printing/Duplicating*	$ -	$ -				
	C4	*Travel/Mileage*	$ -	$ -				
	C5	*Program Specific Insurance*	$ -	$ -				
	C6	*0*	$ -	$ -				
	C7	*0*	$ -	$ -				
	C8	*0*	$ -	$ -				
	C9	*0*	$ -	$ -				
	C10	*0*	$ -	$ -				
	C11	*0*	$ -	$ -				
	C12	*0*	$ -	$ -				
	C13	*0*	$ -	$ -				
	C14	*0*	$ -	$ -				
	C15	*0*	$ -	$ -				
		TOTAL OTHER EXPENSES	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

		W	Z
D	**TOTALS**	PROGRAM COST	FRHD Funds Expended
		$0.00	**$0.00**