

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.

Sin Oa Barnerman

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 Ouestion

 $NEXT \rightarrow$

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 Ouestions

 \leftarrow PREVIOUS NEXT \rightarrow

What is y	your E	IN/Tax	Exempt	501(c)3	designation	ID# *

Do not include the dash.

Service Area*	
What area(s) will this program serve (check all that a	apply).
Bonsall	
De Luz	
Fallbrook	
Rainbow	
None of these areas - not eligible for co	nsideration
Will no less than 80% of the progression communities of Fallbrook, Rainbo	-
Ineligible - Conta	ct the District
Community Health Contract Grants are only a the service recipients reside within the comm Rainb	ow.
u ques	uon
← PREVIOUS	NEXT →

Organization Information

For collaborative submissions please apply under the primary fiscal agent.

16 Questions

← PREVIOUS	NEXI →
Organization Name Please provide the legal name of the organi	ization, as it appears on your 990. If you have a different
DBA or nickname please add that in the box	
Legal Name:	DBA:
Collaborative/Joint Application being submitted in collaboration being submitted in collaboration being submitted in collaboration.	
Collaborative Organization I	Name
This question is ONLY for submissions bein applicant will serve as the fiscal agent and a Please provide the legal name of the collab	ng applied for by two or more agencies. The primary all other questions will refer to the primary applicant orating organization, as it appears on the 990. If you
have a different DBA or nickname please ad	
have a different DBA or nickname please ac	DBA:

Organization Cor	ntact *		
	person who is respor	sible for the submission and mana	gement of this
proposal.			
		J [
First Name		Last Name	
Contact Email *	ddress for the person	Last Name responsible for the submission and	d management of
Contact Email * Please provide the email a	ddress for the person		d management of
Contact Email * Please provide the email a	ddress for the person		d management of
Contact Email * Please provide the email a this proposal.	ddress for the person		d management of
Contact Email * Please provide the email a this proposal.	ddress for the person		d management of
Contact Email * Please provide the email a this proposal.			d management of

Street Address	
Street Address Line 2	
City	State / Province
Postal / Zip Code	
Organization Physica	I Address *
	I Address * e the Organization provides services.
This is the primary address where	
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This is the primary address where Street Address Street Address Line 2 City Postal / Zip Code	e the Organization provides services.
Street Address Street Address Line 2 City Postal / Zip Code Board of Directors *	e the Organization provides services.

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

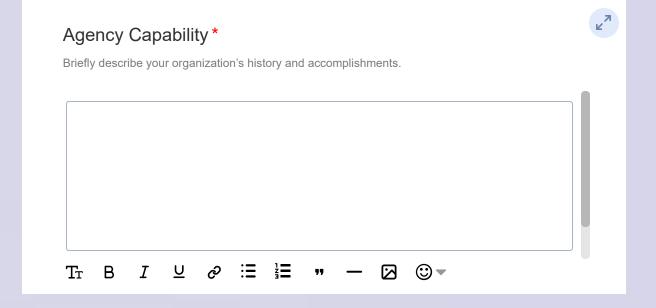
BROWSE FILES

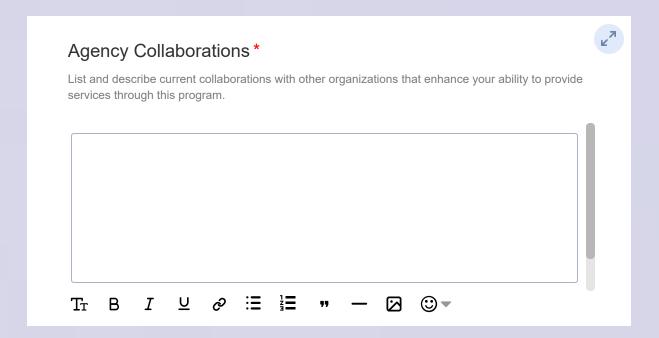
Organization's Mission Statement*

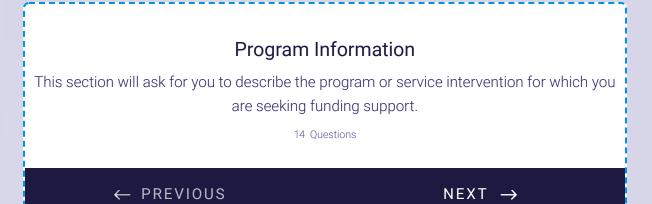
K Z

Type a description

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Program Information - Type * Is this program time bound or ongoing? Ongoing

Type a question

Please select the start and end dates for this program.

		Jan	uary 20	21		
Мо	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%)*	

vou in	dicated tha	at vou do	not collec	t data on	the abov	e question	nlease prov	ide a rationale as to)
								our organization	
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List the percentages of your program participants' gender identification. Percentages must add up to 100%

Percent of program participants

Female	
Male	
Non-binary	
Unknown*	

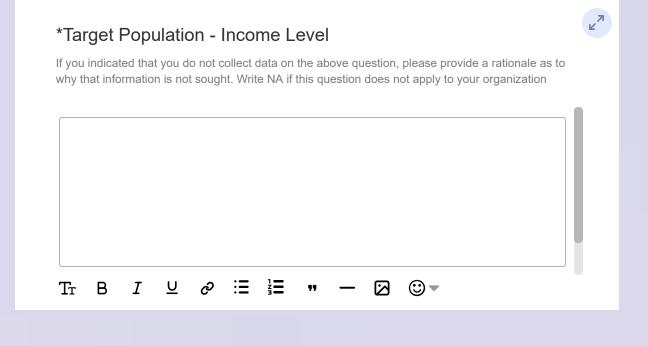
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	-							a rationa organiza		

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

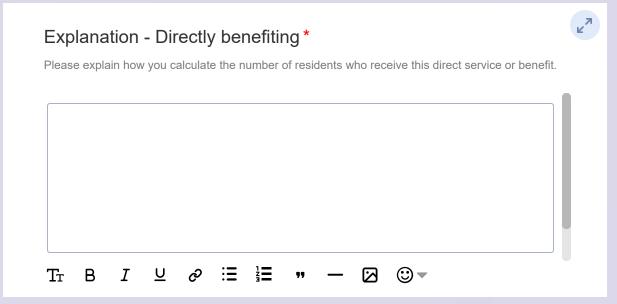
Extremely Low-Income Limits, ceiling of \$32,100	
Very Low (50%) Income Limits, ceiling of \$53,500	
Low (80%) Income Limits, ceiling of \$85,600	
Higher Than Listed Limits	
We do not collect this data (indicate with 100%)*	



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



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.

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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.

Vhat eed?		organiz	zations	within	the co	mmunit	y offer	similar	progra	ıms/s	ervices	that ac	ldress t	his
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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

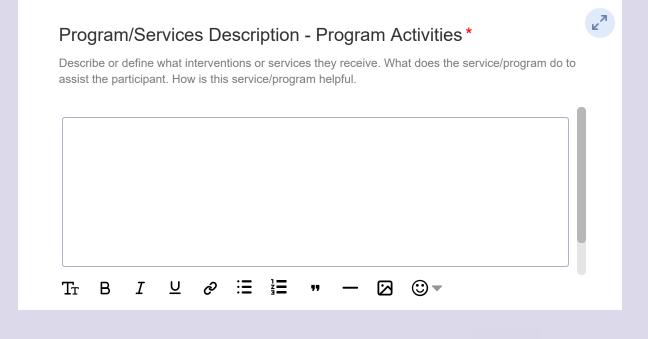
← PREVIOUS

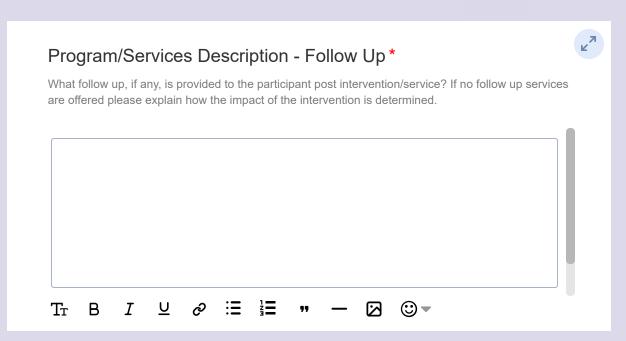
 $NEXT \rightarrow$

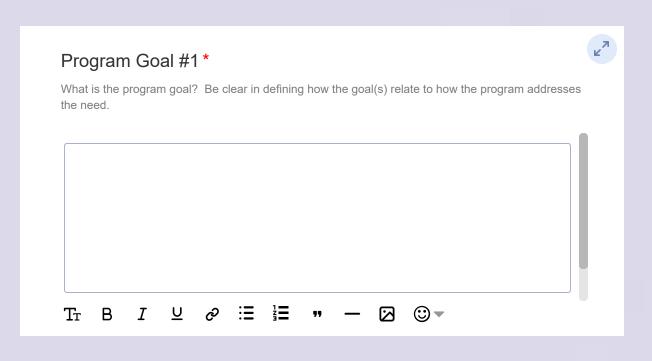
Program/Services Description * Which one of the following categories best describes the primary goal and objectives of your program? Prevention/Education: Supplies/training of health practices or to prevent/control of disease/injury. Treatment: Direct provision of care in medical, dental, vision, or 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.

Economic Stability (Employment, Food Insecurity, Housing Instability, Poverty)
	Quality (Early Childhood Education and Development, Education, High School Graduation, Language and
Social & Community Social Cohesion)	Context (Civic Participation, Discrimination, Incarceration,
Healthcare Access 8 Care, Health Literacy	Quality (Access to Health Care, Access to Primary y)
	It Environment (Access to Foods that Support Healthy ne and Violence, Environmental Conditions, Quality of

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Program Objectives - Goal #1	rogram	Objectives	- Goal #1 *
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ADD BOX FOR ADDITIONAL OBJECTIVE

Additional Program Goals *

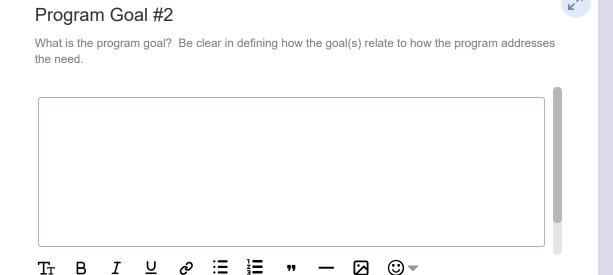
Are there additional Goals for this program?

YES

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.

Prog	gram	ı Ou	tcom	ies/N	Лeas	sural	oles	- Go	al &	Ob	jecti	ves	#1 *		r _y
Define above	n how the medical ways. What program	easura quant	able ac itative i	ivities	and ou	tcome	s the p	rogran	n genei	ates 1	or eac	h obje	ctive s	stated	
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NO



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Program Objectives - Goal #2

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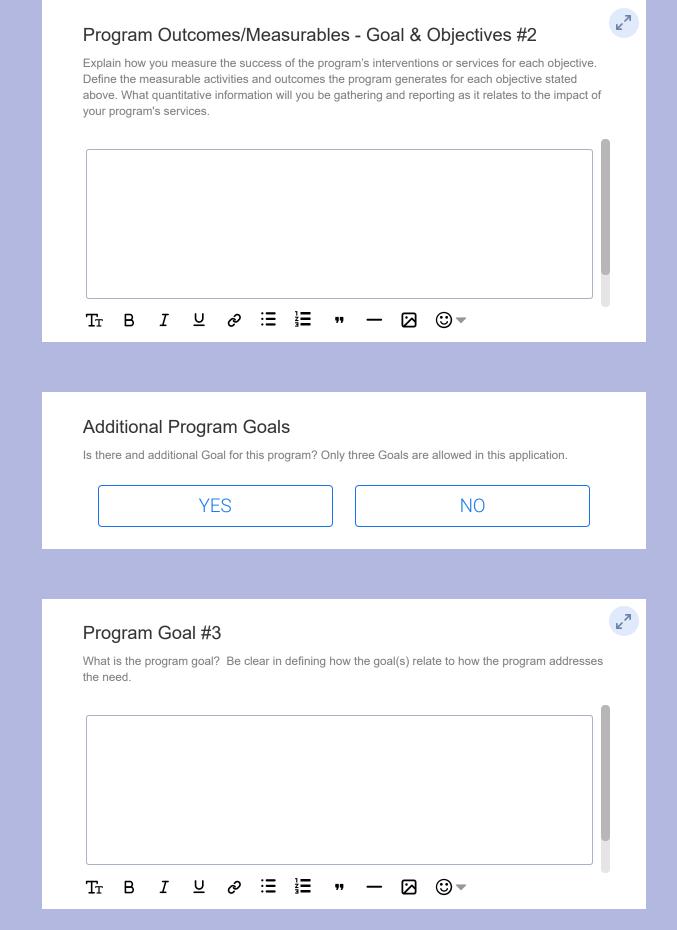
В

Ι

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 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.

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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 Ouestions

Please select the methods by which the funding.	Organization will acknowledge the District's investment of	
Social Media Postings		
Signage at Service Sites		
Print Materials to Service Rec	cipients	
Website Display		
Other		
Anticipated Acknowledgme Please explain how the District's name o social media platforms your organization	or logo will be promoted. If selected, please identify which	
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	al Reporting & Budget Type a subheader	
	7 Questions	
← PREVIOUS	NEXT →	

Anticipated Acknowledgment *

Yes, requ	ested and funded	Yes, red	quested but not fund	led
O Have not	applied before			
Funding Hi	story*			
Have grant funds	awarded to your organizatio	n ever been withdrav	wn, reduced or discontir	nued?
	YES		NO	
_	story - withdrawn, hy funding was withdrawn, re		•	olained
	-		•	olained
	hy funding was withdrawn, re		•	olained
Please explain w	hy funding was withdrawn, re	educed or discontinue	ed.	olained
Please explain w	hy funding was withdrawn, re	educed or discontinue	ed.	olained

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.



ROWSE FILES

Tern	ms and Conditions *	
	king this box certifies that all information presented in or accurate.	attached to this Application is complete
	Rights Reserved by the Board of Directo	rs - found online at
https	s://www.fallbrookhealth.org/community-he	ealth-contracts-grants-policy-
proc	cedures *	

Authori	zed Sigr	nature *		
Please sign	the applicat	tion		

SUBMIT



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.

<u>APPLYING ORGANIZATION</u>: 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.

- > <u>OTHER RESOURCES</u>: 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) should be listed on a separate line.



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

utility 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.



•	FRHD	CHC GRANT	F BUDGET FORM	И	
ency me:		PROGRAM NAME:			
	ne items will correspond with your pro		If the item does not	fully align either le	eave it blank or gro
	it in the best category possible				
Α	INDIRECT EXPENSES:	PROGRAM	APPLYING	OTHER	REQUESTED FROM
A1	Administrative Support	COST	ORGANIZATION	RESOURCES	FRHD
	General Insurance (not program specific				
A2)				
А3	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	-	-	-	-
В	PERSONNEL EXPENSES - PROGRAM	PROGRAM	APPLYING	OTHER	REQUESTED FROM
	SPECIFIC	COST	ORGANIZATION	RESOURCES	FRHD
B1	Salary (list position)				
B2	Salary (list position)				
В3	Salary (list position)				
В4	Salary (list position)				
B5	Payroll Expenses (WC, taxes)				
B6	Benefits				
B7	Other: specify				
	TOTAL PERSONNEL EXPENSE	-	-	-	-
С	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		PROGRAM	% REQUESTED	Ī	_
	TOTAL ALL EXPENSES	COST	FROM FRHD		
		\$ -	#DIV/0!		
FUN	DING SOURCES	1		=	
Е	FUNDS FOR PROGRAM		-		
E1	APPLYING ORGANIZATION		1		
E2	OTHER RESOURCES	-	4		
E3	REQUESTED FROM FRHD Z	-			
		\$ -	NOTE: THIS AMOUNT	SHOULD BE EQUAL TO	YOUR PROJECT COS
	F AGENCY BUDGET				T
F	CALCULATE % of Total Agency		\$ -	#DIV/0!	
	budget that this Program represents.	AGENCY	PROGRAM COST	% of AGENCY	
	buuget tiiat tiiis Program represents.	BUDGET**	PROGRAM COST	% OF AGENCY BUDGET	

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



Agency Name:	0	0						
Program Name:	0							
Total Organization Budget (Current Fiscal Year)		\$	-					
Total Project Budget	(Current Fiscal Year)	\$	-					
Orga	nization Sources of Revenue	S	Sources of Funding					

(This Project Request)

(Total Organization Budget)

0	Φ.Α	Percent	One-time funding?	Φ.Δ	Percent of	One-time funding?
Source of funds	\$ Amount	of Total	(Yes/No)	 \$ Amount	Total	(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.



Age	ncy Name:	0
Prog	gram Name:	0
INST	RUCTIONS:	
	st items from your PRC ng FRHD support.	DJECT BUDGET FORM (Sections A and B) where an expense is indicated, that you are
2 Pr	ovide a brief narrative	description of each budget line item to be funded by the proposed grant.
3 Yo	our narrative should ex	plain why this expense is necessary to the project and why or how FRHD funding would
make	an impact.	
A. IN	DIRECT EXPENSES:	Please indicate by the Line Number and Item Name
#	Name	Narrative:
B. PE	RSONNEL EXPENSE	S -PROGRAM SPECIFIC
#	Name	Narrative:
	RECT PROGRAM EXI	
#	Name	Narrative:



FRHD CHC GRANT BUDGET REPORTING FORM

	11015 0110 1		
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.

Α	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	\$ -	\$ -				
А3	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	\$0.0
В	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)	\$ -	\$ -	USED Q1	USED Q2	USED Q3	USED Q4
B2	Salary (list position)	\$ -	\$ -				
ВЗ	Salary (list position)	\$ -	\$ -				
В4	Salary (list position)	\$ -	\$ -				
B5	Payroll Expenses (WC, taxes)	\$ -	\$ -				
В6	Benefits	\$ -	\$ -				
В7	Other: specify	\$ -	\$ -				
	TOTAL PERSONNEL EXPENSE	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.0
С	DIRECT PROGRAM EXPENSES	PROGRAM COST	REQUESTED FROM FRHD	AMOUNT USED Q1	AMOUNT USED Q2	AMOUNT USED Q3	AMOUNT USED Q4
C1	Fauriamant	Φ.		OOLD Q1	OOLD Q2	OOLD QO	COLD Q+
O I	Equipment	\$ -	\$ -				
C2	Program/Project Supplies	\$ -	\$ - \$ -				
	• •						
C2	Program/Project Supplies	\$ -	\$ -				
C2 C3	Program/Project Supplies Printing/Duplicating	\$ - \$ -	\$ - \$ -				
C2 C3 C4	Program/Project Supplies Printing/Duplicating Travel/Mileage	\$ - \$ - \$ -	\$ - \$ - \$ -				
C2 C3 C4 C5	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance	\$ - \$ - \$ -	\$ - \$ - \$ - \$ -				
C2 C3 C4 C5 C6	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0	\$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ -				
C2 C3 C4 C5 C6	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0	\$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ -				
C2 C3 C4 C5 C6 C7	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0 0 0	\$ - \$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ - \$ -				
C2 C3 C4 C5 C6 C7 C8 C9	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0 0 0 0	\$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ - \$ - \$ -				
C2 C3 C4 C5 C6 C7 C8 C9 C10 C11	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0 0 0 0 0	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -				
C2 C3 C4 C5 C6 C7 C8 C9 C10	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0 0 0 0 0 0	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -				
C2 C3 C4 C5 C6 C7 C8 C9 C10 C11	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0 0 0 0 0 0 0 0	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$ \$ \$ - \$				
C2 C3 C4 C5 C6 C7 C8 C9 C10 C11 C12 C13	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0 0 0 0 0 0 0 0 0 0	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -				
C2 C3 C4 C5 C6 C7 C8 C9 C10 C11 C12 C13	Program/Project Supplies Printing/Duplicating Travel/Mileage Program Specific Insurance 0 0 0 0 0 0 0 0 0 0 0 0 0	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ 5 - \$	\$0.00	\$0.00	\$0.00	\$0.0

D TOTALS

PROGRAM COST FRHD Funds Expended

\$0.00 \$0.00