

**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
<b>Category Total</b>							

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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			
Category Totals			
Category Totals			
TOTAL PROGRAM COSTS			

Contractor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_