Tennessee Department of Health
Funding Information Summary

AGENCY NAME: _____

ADDRESS: _____

CITY: _____ STATE_____ ZIP _____

REPORTING PERIOD: *FROM* ____/____/____
MO DAY YR
THRU ____/____/____
MO DAY YR

INDIRECT RATE OR COST ALLOCATION: YES NO

DOES YOUR ORGANIZATION HAVE AN APPROVED INDIRECT RATE? [ ] [ ]

OR

DOES YOUR ORGANIZATION HAVE AN APPROVED COST ALLOCATION PLAN? [ ] [ ]

Name of organization that approved the Rate or PI _____

IF COST ALLOCATION IS APPLIED, INDICATE THE METHOD OF ALLOCATION:

_____ Ratio of direct program salaries to total direct salaries applied to administrative cost.

_____ Ratio of direct program expenditures to total direct expenditures applied to administrative cost.

_____ Cost step down

_____ Other: Describe _____

Is your organization:

_____ A private not-for-profit organization?
_____ A state college or university, or part of a city or county government?

Director _____ _____
Phone Number

Preparer of Report _____ _____
Phone Number

Date: _____

FUNDSHT9.WK4 ATTACHMENT _____