**EXHIBIT D-DCF B-3 Budget Form**

**CAC Treatment Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **BUDGET CATEGORIES12-Month Budget**  | **TOTAL COSTS** | **DCF Funding request** | **Leveraging Other Cash or In-Kind Funding Sources\*** |  |  |
| A. Consultants & Professional Fees Personnel (List each position) |   |   |   |   |
| B. Materials & Supplies |   |   |   |   |
| C. Contracts with Agencies to provide CAC Services |   |   |   |   |
| D. Transportation Services |   |   |   |   |
| E. Other |   |   |   |   |
|  |   |   |   |   |
| F. Total Cost |   |   |   |   |
| G. Revenue (deduct)\* | ( ) | n/a | n/a |   |
| **H. Funding Request** |   | n/a | n/a |   |
| The budget request shall indicate the Agency’s total proposed budget for **delivery of the services** reduced by the other sources of funding. If applicable, indicate the sources of leveraged funding and the dollar amounts for each below: |   |
| Other Sources of Funding for this Program:(Specify These) |   |   |   |   |
| Other Funding Amounts: | 0 | 0 | 0 |   |