

2013 SUPPLEMENTAL APPROPRIATION

Human Services Block Grant
DEPARTMENT/OFFICE

Date: 7/22/2013

Description: Supplemental Appropriation to record the re-allocation of Human Services Block Grant funding.

| ACCOUNT NAME | ACCOUNT NUMBER | AMOUNT OF INCREASE | AMOUNT OF DECREASE |
|---|-----------------|--------------------|--------------------|
| CHANGE IN EXPENDITURES: | | | |
| HAP Case Management - General Contracted Services | 35474200 58000 | 5,000.00 | |
| MH - Psychiatric Inpatient - Holy Spirit Hospital | 11451611 513220 | | 5,000.00 |
| | | | |
| | | | |
| | | 5,000.00 | 5,000.00 |

| | | | |
|------------------------------|-----------------|----------|----------|
| CHANGE IN REVENUES: | | | |
| HAP Revenue - HAP Allocation | 35470000 064610 | 5,000.00 | |
| MH Revenue - Base Allocation | 11450000 061000 | | 5,000.00 |
| | | | |
| | | 5,000.00 | 5,000.00 |

NET CHANGE TO BUDGET 0.00 0.00

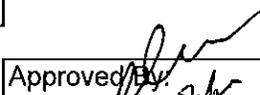
Positive (Negative) cash flow 0.00

Explanation:

Final FY 12-13 Shift of HSBG funding - Transfer unspent block grant funds from MH to HAP to be used for rental assistance.

Prepared By:
Stacy Rowe, Human Service Fiscal Manager

Posted By:

Approved By: 


8. TERM OF CONTRACT/REPORT/GRANT _____

9. TOTAL AMOUNT OF CONTRACT/REPORT/GRANT: _____

If contract, are any of the costs covered by a grant? _____ Yes _____ No

If yes, name of grant: _____

Total amount covered by grant? _____

Is this State, Federal or other funding and what is percentage of each? (list below)

General Fund _____ State _____ Federal _____ Other _____

If no cost to county, why? _____

If a renewal contract, amount of increase/decrease over last contract: _____

If this is a multiyear, contract what is the annual increase? _____

10. IF OVER \$4,000.00, HAVE REQUEST FOR QUOTES BEEN COMPLETED? _____ Yes
_____ No If yes please attach copies of all information.

IF OVER \$10,000.00, HAVE REQUEST FOR BIDS BEEN COMPLETED? _____ Yes
_____ No If yes please attach copies of all bid information.

11. Is the company on State Contract? _____ Yes _____ No

12. Contractor/Service provider checked to determine for suspension or debarment by the County, Commonwealth, any other State or Federal Government. Is the Contractor/Service provider suspended or debarred? _____ Yes _____ No The following web sites are to be utilized for this determination (<http://www.oig.hhs.gov/exclusions/index.asp> for healthcare providers and <https://www.epls.gov/> for general providers)

If checked yes, please explain _____

Department Head/Manager Approval Signature: Teresa Beckner

****Attach this cover sheet to each document (needing Board signatures) and forward to Chris Daywalt in the Commissioners' Office no later than 4:30 PM, Thursday. All contracts/documents will be signed and executed during board action time at a regularly scheduled meeting.**