Education & Outreach
Fiscal Provider Orientation
FY 2022

September 9, 2021

Frantzsou Balthazar-Toussaint
Fiscal Manager
Infectious Disease Bureau

Learning Objective

- To review BPHC's Infectious Disease Bureau fiscal rules as they related to your service delivery in FY22
- To go over changes in budget revisions that are effective starting this fiscal year.

Fiscal Update

FY22 Contract Packet

- Contract packet for FY22 were sent via SignNow back on July 28 and emailed on July 29, 2021
- Only fully completed contract packet with no missing documents will be executed
- Purchase Order (PO) number cannot be issued without an executed contract
- Delays in contract execution create delays in PO creation and subsequently delays in invoice payments

Budget Revision Request

- Budget revision request documents have been updated to streamline the process

Fiscal Rules

For a detailed review of Fiscal Rules please see the FY22 Provider Manual

Some key reminders:

- It is expected that 100% of funded agencies FY22 award is spent by the end of the funded fiscal year
- Reimbursement for service delivery costs will only be made in accordance with funded agencies' most current (FY22) budget and Scope of Service
- **Administrative** costs/HHS-Approved **Indirect Rate** costs are capped at 12%
- Administrative activities must be clearly labeled and itemized on E&O budgets
- Funded agencies are responsible for:
  - ✓ Tracking all administrative expenses
  - ✓ Providing expense reports as backup documentation for invoices
- Agencies wishing to use an **Indirect Rate**, must provide documentation of Certificate of Indirect Costs that is **HHS-negotiated** and signed by an individual authorized to sign on behalf of the agency
- Agencies with an approved indirect rate do not need to submit indirect expenses backup with their invoices

Fiscal Rules

- **Administrative costs:**
  - **Usual and recognized administrative overhead activities include:**
    - Utilities, Rent, Maintenance, Facility costs
    - Costs of management oversight of the specific program including:
      - Program coordination
      - Clerical, financial, and management staff not directly related to patient care
      - Program evaluation
      - Liability insurance
      - Audits
      - Computer hardware/ software not directly related to patient care
  - **Agencies with HHS-negotiated Indirect Rate do not need to submit expenses backup for their administrative expense.**
    - Indirect Rate must be clearly labeled on E&O budgets

Budget Overview

Direct Cost

- All E&O paid staff that provide direct services

Other Direct Cost

- Non-Personnel Direct Costs, i.e. Supplies, Travel, Training, etc.

Administrative Cost

- Itemized Administrative Cost, 12% Cap; or
- HHS Indirect Approved Rate, 12% Cap

Sample Budget

Boston Public Health Commission
Infectious Disease Bureau
Community Based Prevention
FY 2022
July 1, 2021 - June 30, 2022
Agency Name
EDUCATION & OUTREACH

Direct Cost	Personnel	Salary	FTE	Months	Annual
Health Outreach Worker	M. Jones	$32,000	1.00	12	$32,000
Administrative Assistant	J. Smith	$25,000	0.50	12	$12,500
		SUBTOTAL	1.50		$44,500
		FRINGE	29.30%		$13,039
		PERSONNEL TOTAL			$57,539
Other Direct Cost					
Incentives					$1,500
Office Supplies					$1,500
Educational Supplies					$2,500
		SUBTOTAL			$5,500
		DIRECT COST TOTAL			$63,039

Administrative Cost	Personnel	Salary	FTE	Months	Annual
Program Manager	J. Doe	$63,273	0.05	12	$3,164
		SUBTOTAL	0.05		$3,164
		FRINGE	29.30%		$927
		SUBTOTAL			$4,091
Other Administrative Cost					
Accounting Cost					$825
Financial Reporting Costs					$2,000
Payroll Costs					$649
		SUBTOTAL			$3,474
		ADMIN COST TOTAL			$7,565
		DIRECT COST TOTAL			$63,039
		ADMIN COST TOTAL (BPHC Community Based Prevention Cap (12%))			$7,565
		E&O SERVICE AWARD TOTAL			**$70,603**

Invoices

Invoice = Invoice Cover Sheet + Back-up Documentation

BPHC City Funding

Monthly Invoice

Agency Name:	**ENTER AGENCY NAME HERE**
Pay To:	**WRITE COMPLETE AGENCY NAME**
Address:	**ENTER AGENCY ADDRESS HERE**
Bill To:	Boston Public Health Commission Procure to Pay Office 1010 Massachusetts Avenue Boston, MA 02118
Funded Service:	**EDUCATION & OUTREACH**
Activity#:	**6226007**
BPHC PO#	**Enter new PO#**

INFECTIOUS DISEASE BUREAU USE ONLY	
APPROVED FOR PAYMENT	
Date:	

Funding Source:	**City of Boston**
Program:	**Community Based Prevention**
Invoice Submission Date:	**Enter submission Date**
Billing Period:	**Enter Billing Period**
Invoice #:	**EO(MONTH)FY22**

PERSONNEL	*FTE*	*Budget (A)*	*Amount this Invoice (B)*	*Cumulative Billing (C)*	*Remaining Balance (D)*
Program Director	*0.00*	*$0*	*$0*	*$0*	*$0*
Health Educator	*0.00*	*$0*	*$0*	*$0*	*$0*
Public Health Navigator	*0.00*	*$0*	*$0*	*$0*	*$0*
		$0	*$0*	*$0*	*$0*
Sub-total	*0.00*	*$0*	*$0*	*$0*	*$0*
Fringe	*30.00%*	*$0*	*$0*	*$0*	*$0*
Personnel Totals		***$0***	*$0*	*$0*	*$0*
OTHER DIRECT COST					
Local Travel		*$0*	*$0*	*$0*	*$0*
Educational Supplies		*$0*	*$0*	*$0*	*$0*
Office Supplies		*$0*	*$0*	*$0*	*$0*
		$0	*$0*	*$0*	*$0*
Sub-total		*$0*	*$0*	*$0*	*$0*
DIRECT COST TOTAL		*$0*	*$0*	*$0*	*$0*
ADMINISTRATIVE COST (BPHC Cap 12%)					
Program Director	*0.00*	*$0*	*$0*	*$0*	*$0*
Fringe	*0%*	*$0*	*$0*	*$0*	*$0*
ADMINISTRATIVE COST TOTAL	*12.0%*	*$0*	*$0*	*$0*	*$0*
TOTALS EXPENSE		***$0***	*$0*	*$0*	*$0*

Invoice Amount ***$0***

I hereby certify that the bills, receipts, and payroll documentation attached to this invoice are expenditures solely associated with the Ryan White Part A funding.

Prepared by:	*Authorized by:*
Contact Name:	**Name:**
Phone:	**Title:**
Email:	**Signature (blue ink):**

Invoice overview

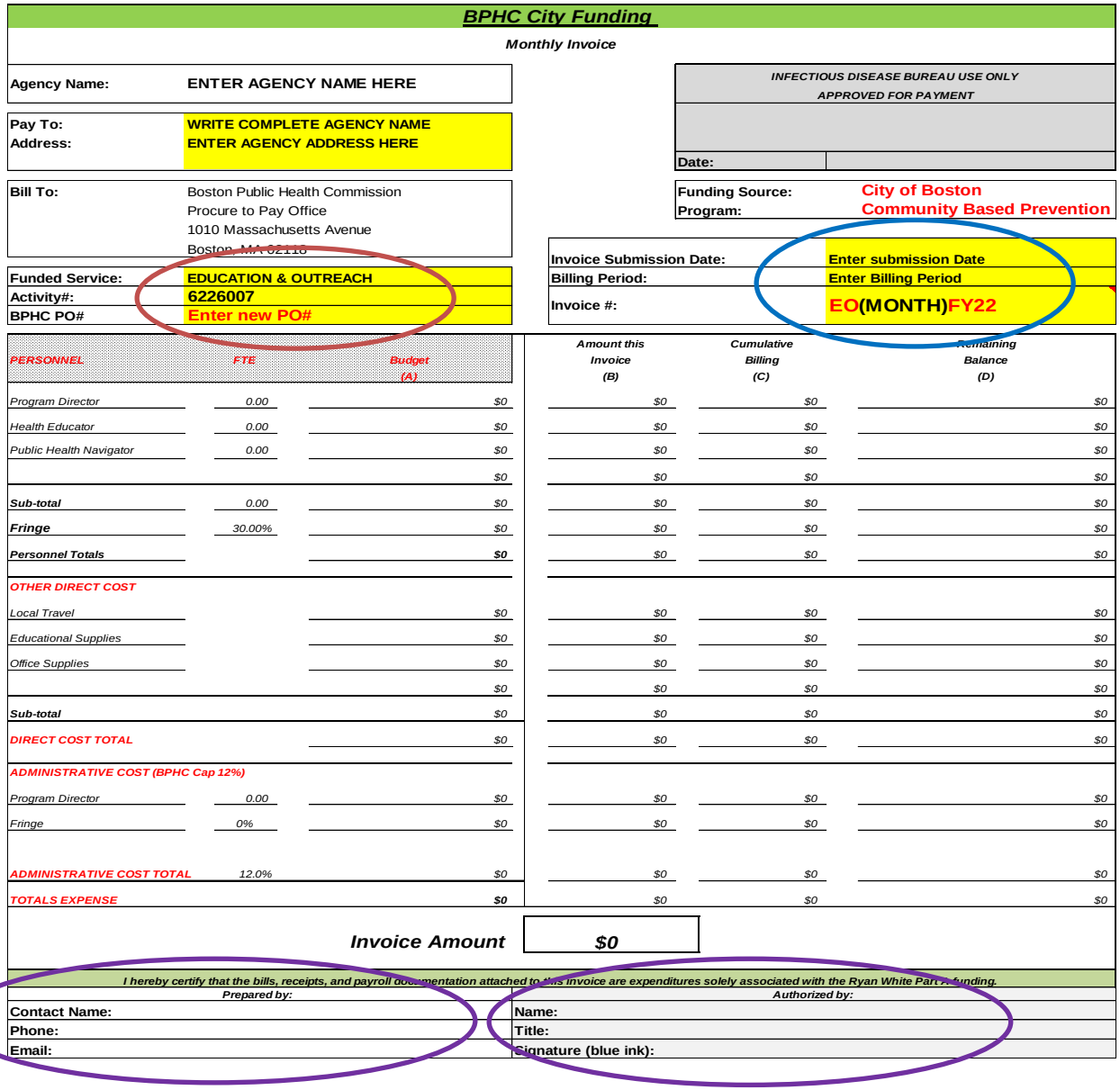
- Invoice cover sheet format must match BPHC's format exactly to avoid mistake – See FY22 Provider Manual
- Invoice cover sheet must always match the most current approved budget EXACTLY
- Invoice # must be unique for each billing month, have less than 20 characters, and must be legible
- Invoice # should not be handwritten
- Invoice PO # should be the CORRECT and CURRENT Fiscal Year PO # (FY22 PO # as of July 1, 2021)
- There should be sufficient and proper back-up documentation for each invoice submitted

Invoice Cover Sheet

Invoice cover sheet **format** must match current budget and invoice template format – see FY22 Provider Manual

Invoice Activity number is updated every fiscal year and is valid the for whole fiscal year

Invoice PO number is updated every fiscal year – New POs are sent to agency's fiscal staff at the beginning of the fiscal year and is valid for the whole year unless otherwise indicated by BPHC



BPHC City Funding

Monthly Invoice

Agency Name:	ENTER AGENCY NAME HERE
Pay To:	WRITE COMPLETE AGENCY NAME
Address:	ENTER AGENCY ADDRESS HERE
Bill To:	Boston Public Health Commission Procure to Pay Office 1010 Massachusetts Avenue Boston, MA 02118
Funded Service:	EDUCATION & OUTREACH
Activity#:	6226007
BPHC PO#	Enter new PO#

INFECTIOUS DISEASE BUREAU USE ONLY
APPROVED FOR PAYMENT
Date:

Funding Source:	City of Boston
Program:	Community Based Prevention
Invoice Submission Date:	Enter submission Date
Billing Period:	Enter Billing Period
Invoice #:	EO(MONTH)FY22

PERSONNEL	FTE	Budget (A)	Amount this Invoice (B)	Cumulative Billing (C)	Remaining Balance (D)
Program Director	0.00	$0	$0	$0	$0
Health Educator	0.00	$0	$0	$0	$0
Public Health Navigator	0.00	$0	$0	$0	$0
		$0	$0	$0	$0
Sub-total	0.00	$0	$0	$0	$0
Fringe	30.00%	$0	$0	$0	$0
Personnel Totals		$0	$0	$0	$0
OTHER DIRECT COST					
Local Travel		$0	$0	$0	$0
Educational Supplies		$0	$0	$0	$0
Office Supplies		$0	$0	$0	$0
		$0	$0	$0	$0
Sub-total		$0	$0	$0	$0
DIRECT COST TOTAL		$0	$0	$0	$0
ADMINISTRATIVE COST (BPHC Cap 12%)					
Program Director	0.00	$0	$0	$0	$0
Fringe	0%	$0	$0	$0	$0
ADMINISTRATIVE COST TOTAL	12.0%	$0	$0	$0	$0
TOTALS EXPENSE		$0	$0	$0	$0

Invoice Amount $0

I hereby certify that the bills, receipts, and payroll documentation attached to this invoice are expenditures solely associated with the Ryan White Part A funding.

Prepared by:	Authorized by:
Contact Name:	Name:
Phone:	Title:
Email:	Signature (blue ink):

Invoice number changes every fiscal year to match current fiscal year and billing months

Prepared by/Authorized by section must be filled out completely

Invoice Cover Sheet – Top Part

BPHC City Funding	
Monthly Invoice	
Agency Name:	**ENTER AGENCY NAME HERE**
Pay To:	**WRITE COMPLETE AGENCY NAME**
Address:	**ENTER AGENCY ADDRESS HERE**
Bill To:	Boston Public Health Commission Procure to Pay Office 1010 Massachusetts Avenue Boston, MA 02118
Funded Service:	**EDUCATION & OUTREACH**
Activity#:	**6226007**
BPHC PO#	**Enter new PO#**

INFECTIOUS DISEASE BUREAU USE ONLY	
APPROVED FOR PAYMENT	
Date:	

Funding Source:	**City of Boston**
Program:	**Community Based Prevention**

Invoice Submission Date:	**Enter submission Date**
Billing Period:	**Enter Billing Period**
Invoice #:	**EO(MONTH)FY22**

Invoice Activity number is updated every fiscal year and is valid the for whole fiscal year

Invoice number changes every fiscal year to match current fiscal year and billing months

Invoice number should:

- **Specify program**: EO – for Education & Outreach
- Specify Month: Month (abbreviated)
- Specify Fiscal Year: Fiscal Year (abbreviated)

Example: **EOJulFY22**

Invoice Cover Sheet - Middle Part

PERSONNEL	FTE	Budget (A)	Amount this Invoice (B)	Cumulative Billing (C)	Remaining Balance (D)
Program Director	0.00	$0	$0	$0	$0
Health Educator	0.00	$0	$0	$0	$0
Public Health Navigator	0.00	$0	$0	$0	$0
		$0	$0	$0	$0
Sub-total	0.00	$0	$0	$0	$0
Fringe	30.00%	$0	$0	$0	$0
Personnel Totals		**$0**	$0	$0	$0
OTHER DIRECT COST					
Local Travel		$0	$0	$0	$0
Educational Supplies		$0	$0	$0	$0
Office Supplies		$0	$0	$0	$0
		$0	$0	$0	$0
Sub-total		$0	$0	$0	$0
DIRECT COST TOTAL		$0	$0	$0	$0
ADMINISTRATIVE COST (BPHC Cap 12%)					
Program Director	0.00	$0	$0	$0	$0
Fringe	0%	$0	$0	$0	$0
ADMINISTRATIVE COST TOTAL	12.0%	$0	$0	$0	$0
TOTALS EXPENSE		**$0**	$0	$0	$0

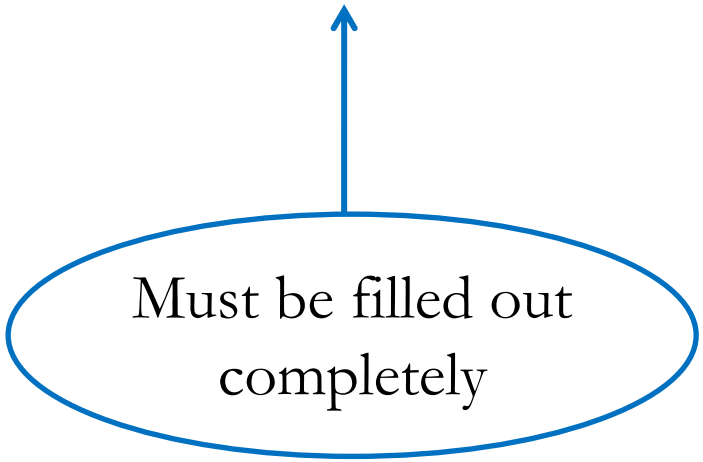
Invoice Amount ***$0***

This side must match current budget

Cumulative Billing must reflect accurate billing over the course of the fiscal year.

Invoice Cover Sheet – Bottom Part

I hereby certify that the bills, receipts, and payroll documentation attached to this invoice are expenditures solely associated with the Ryan White Part A funding.	
Prepared by:	*Authorized by:*
Contact Name:	Name:
Phone:	Title:
Email:	Signature (blue ink):



Invoice Backup Documentation

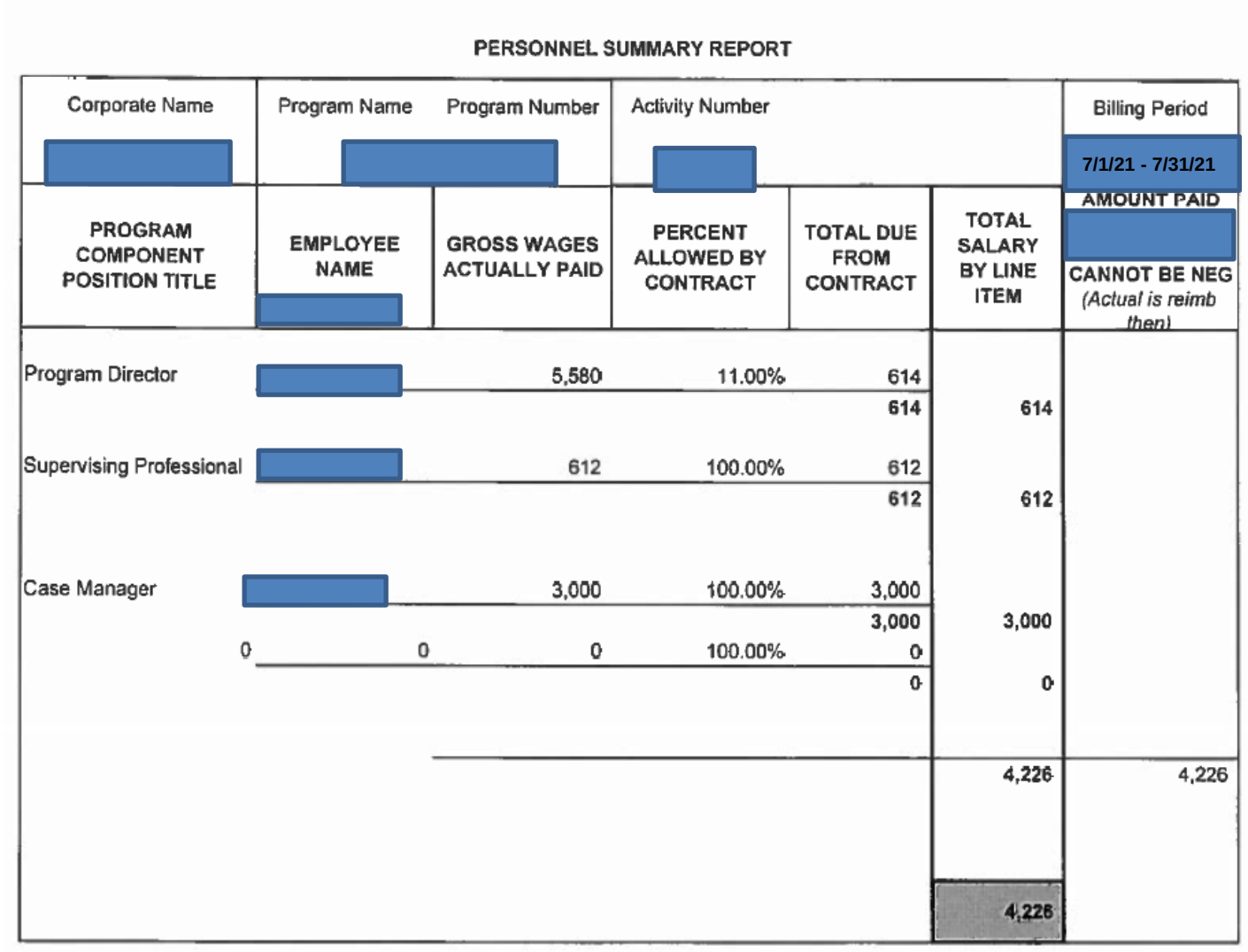
Invoice Backup Documentation should include:

- A summary of the E&O program's direct cost/personnel expenses
  - This summary should serve as a cover page for the payroll back-up.
  - This summary should show the calculations for any split billing (<1 FTE staff)

- A summary of the E&O program other direct cost/below line item expenses
  - This summary is a must for programs with more than one other direct costs/below line items and where multiple receipts are submitted as back-up for a single line item. For instance, multiple receipts may be submitted for a staff travel line. The summary page must show the additions of all the receipts that make up the total monthly expense for that staff travel line.

Direct Cost/Personnel Expenses Summary Page

Example:



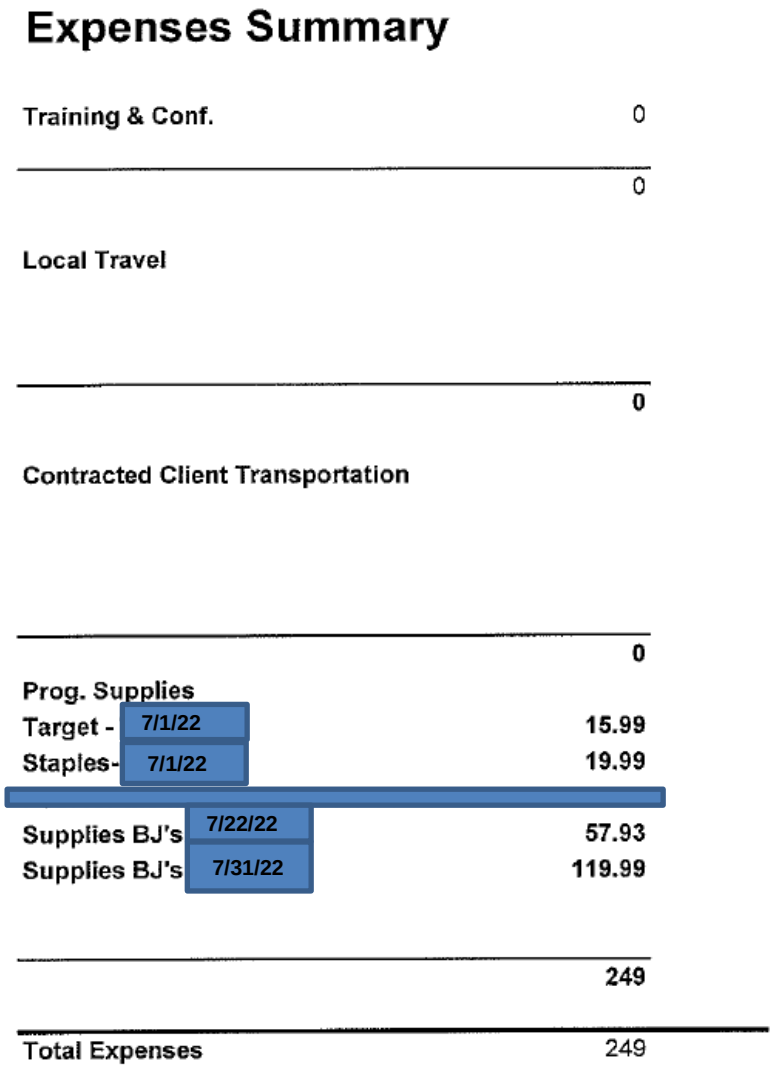
PERSONNEL SUMMARY REPORT

Corporate Name	Program Name / Program Number	Activity Number	Billing Period
[redacted]	[redacted]	[redacted]	7/1/21 - 7/31/21

PROGRAM COMPONENT POSITION TITLE	EMPLOYEE NAME	GROSS WAGES ACTUALLY PAID	PERCENT ALLOWED BY CONTRACT	TOTAL DUE FROM CONTRACT	TOTAL SALARY BY LINE ITEM	AMOUNT PAID [redacted] CANNOT BE NEG (Actual is reimb then)
Program Director	[redacted]	5,580	11.00%	614		
				614	614	
Supervising Professional	[redacted]	612	100.00%	612		
				612	612	
Case Manager	[redacted]	3,000	100.00%	3,000		
				3,000	3,000	
0	0	0	100.00%	0		
				0	0	
					4,226	4,226
					4,226	

Other Direct Cost Summary Page

Example:



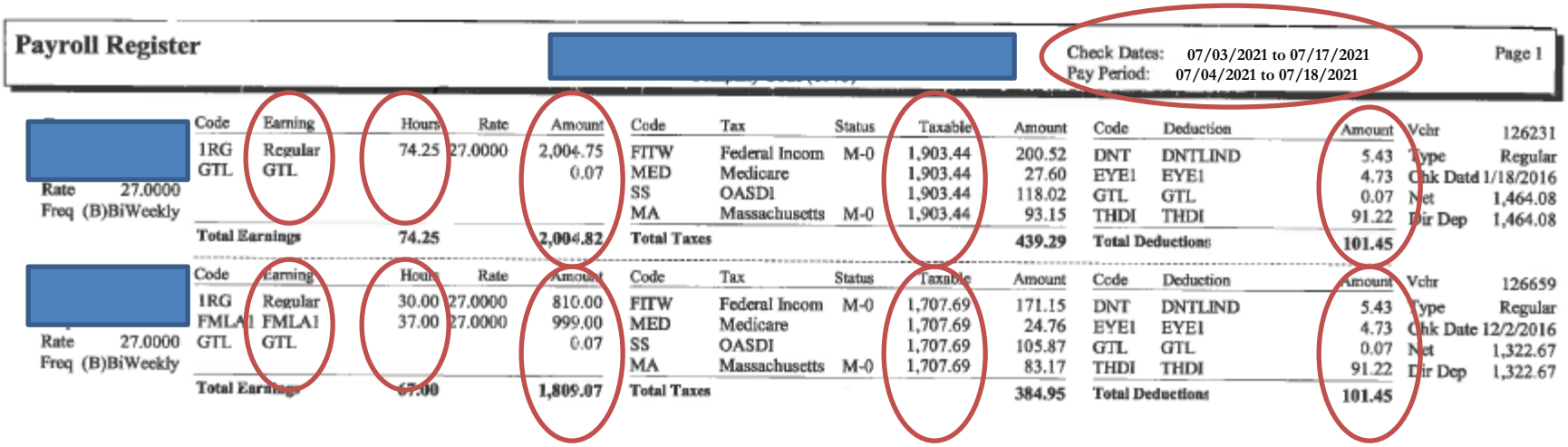
Expenses Summary

Training & Conf.	0
	0
Local Travel	
	0
Contracted Client Transportation	
	0
Prog. Supplies	
Target - 7/1/22	15.99
Staples- 7/1/22	19.99
Supplies BJ's 7/22/22	57.93
Supplies BJ's 7/31/22	119.99
	249
Total Expenses	249

Invoice Backup: Direct Cost/Personnel Expenses

- **<u>Personnel</u> Reimbursement Request:**
  - Must include a page summarizing all the personnel expenses (Summary Page)
  - Must include copies of payroll registers (total earnings, taxes, etc.) for all staff being paid by your E&O funding. Some examples of payroll registers are:
    - Payroll Register
    - ADP
    - PAYCHEX

Payroll Register Sample



Payroll Register [redacted]

Check Dates: 07/03/2021 to 07/17/2021
Pay Period: 07/04/2021 to 07/18/2021
Page 1

[redacted]
Rate 27.0000
Freq (B)BiWeekly

Code	Earning	Hours	Rate	Amount
1RG	Regular	74.25	27.0000	2,004.75
GTL	GTL			0.07
Total Earnings		**74.25**		**2,004.82**

Code	Tax	Status	Taxable	Amount
FITW	Federal Incom	M-0	1,903.44	200.52
MED	Medicare		1,903.44	27.60
SS	OASDI		1,903.44	118.02
MA	Massachusetts	M-0	1,903.44	93.15
Total Taxes				**439.29**

Code	Deduction	Amount
DNT	DNTLIND	5.43
EYE1	EYE1	4.73
GTL	GTL	0.07
THDI	THDI	91.22
Total Deductions		**101.45**

Vchr 126231
Type Regular
Chk Date 1/18/2016
Net 1,464.08
Dir Dep 1,464.08

[redacted]
Rate 27.0000
Freq (B)BiWeekly

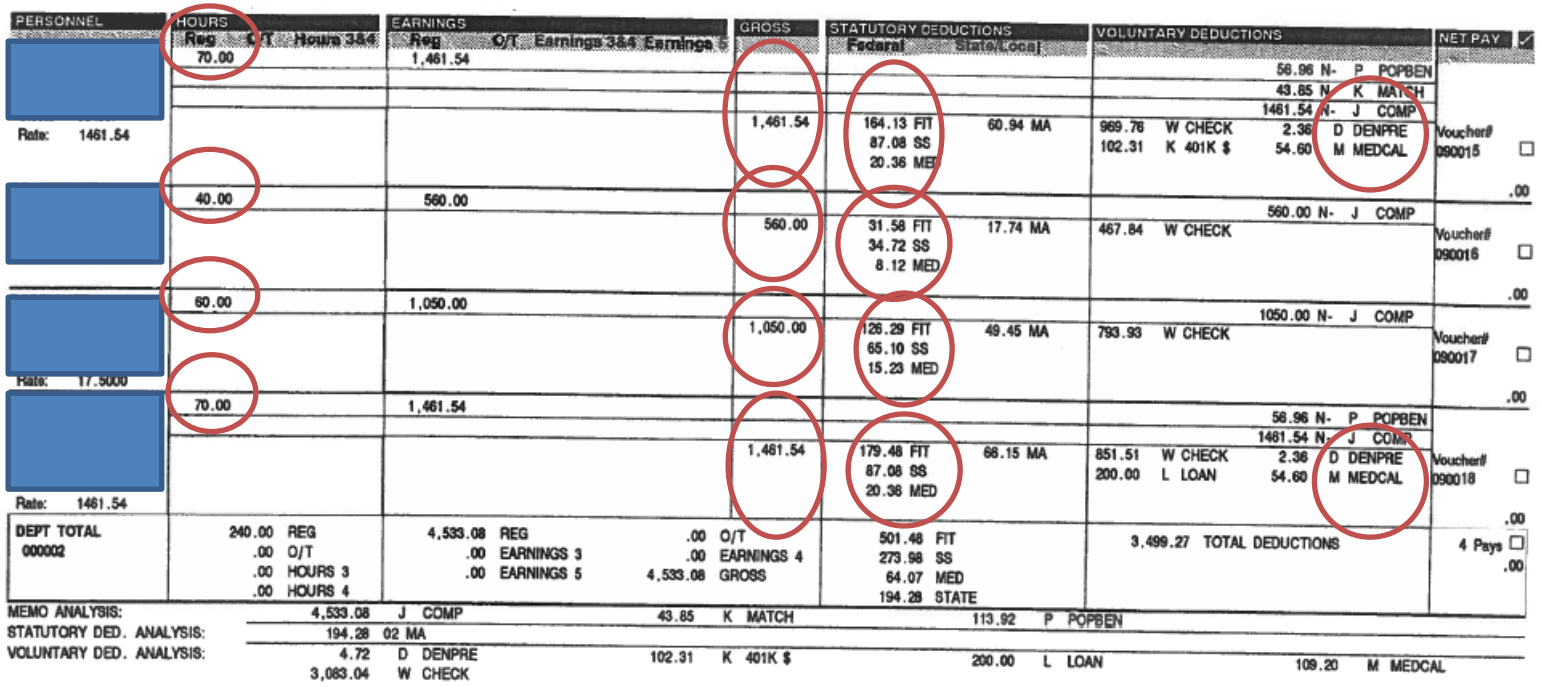
Code	Earning	Hours	Rate	Amount
1RG	Regular	30.00	27.0000	810.00
FMLA1	FMLA1	37.00	27.0000	999.00
GTL	GTL			0.07
Total Earnings		**67.00**		**1,809.07**

Code	Tax	Status	Taxable	Amount
FITW	Federal Incom	M-0	1,707.69	171.15
MED	Medicare		1,707.69	24.76
SS	OASDI		1,707.69	105.87
MA	Massachusetts	M-0	1,707.69	83.17
Total Taxes				**384.95**

Code	Deduction	Amount
DNT	DNTLIND	5.43
EYE1	EYE1	4.73
GTL	GTL	0.07
THDI	THDI	91.22
Total Deductions		**101.45**

Vchr 126659
Type Regular
Chk Date 12/2/2016
Net 1,322.67
Dir Dep 1,322.67

ADP Sample



PERSONNEL	HOURS Reg	O/T	Hours 3&4	EARNINGS Reg	O/T	Earnings 3&4	Earnings 5	GROSS	STATUTORY DEDUCTIONS Federal	State/Local	VOLUNTARY DEDUCTIONS	NET PAY
[redacted]	70.00			1,461.54							56.96 N- P POPBEN	
											43.85 N- K MATCH	
Rate: 1461.54								1,461.54	164.13 FIT 87.08 SS 20.36 MED	60.94 MA	1461.54 N- J COMP 969.76 W CHECK 102.31 K 401K $	2.36 D DENPRE 54.60 M MEDCAL
												Voucher# 090015 ☐
[redacted]	40.00			560.00								.00
								560.00	31.58 FIT 34.72 SS 8.12 MED	17.74 MA	560.00 N- J COMP 467.84 W CHECK	
												Voucher# 090016 ☐
[redacted]	60.00			1,050.00								.00
								1,050.00	126.29 FIT 65.10 SS 15.23 MED	49.45 MA	1050.00 N- J COMP 793.93 W CHECK	
Rate: 17.5000												Voucher# 090017 ☐
[redacted]	70.00			1,461.54								.00
											56.96 N- P POPBEN	
											1461.54 N- J COMP	
								1,461.54	179.48 FIT 87.08 SS 20.36 MED	66.15 MA	851.51 W CHECK 200.00 L LOAN	2.36 D DENPRE 54.60 M MEDCAL
Rate: 1461.54												Voucher# 090018 ☐
												.00
DEPT TOTAL 000002	240.00 REG .00 O/T .00 HOURS 3 .00 HOURS 4			4,533.08 REG .00 EARNINGS 3 .00 EARNINGS 5		.00 O/T .00 EARNINGS 4 4,533.08 GROSS			501.48 FIT 273.98 SS 64.07 MED 194.28 STATE		3,499.27 TOTAL DEDUCTIONS	4 Pays ☐ .00

MEMO ANALYSIS:	4,533.08	J COMP	43.85	K MATCH	113.92	P POPBEN			
STATUTORY DED. ANALYSIS:	194.28	02 MA							
VOLUNTARY DED. ANALYSIS:	4.72	D DENPRE	102.31	K 401K $	200.00	L LOAN	109.20	M MEDCAL	
	3,083.04	W CHECK							

ADP Payroll Register [redacted]

Batch : 2249-010 Period Ending : 02/24/2017 Week 09
Service Center : 010 Pay Date : 03/03/2017 Page 4

Paychex Sample

COMPENSATION REPORT [redacted]

CHECK DATES 02/03/2017 TO 02/17/2017 03/08/2017
PERIOD BEGIN 01/15/2017 PERIOD END 02/11/2017 PAGE 1

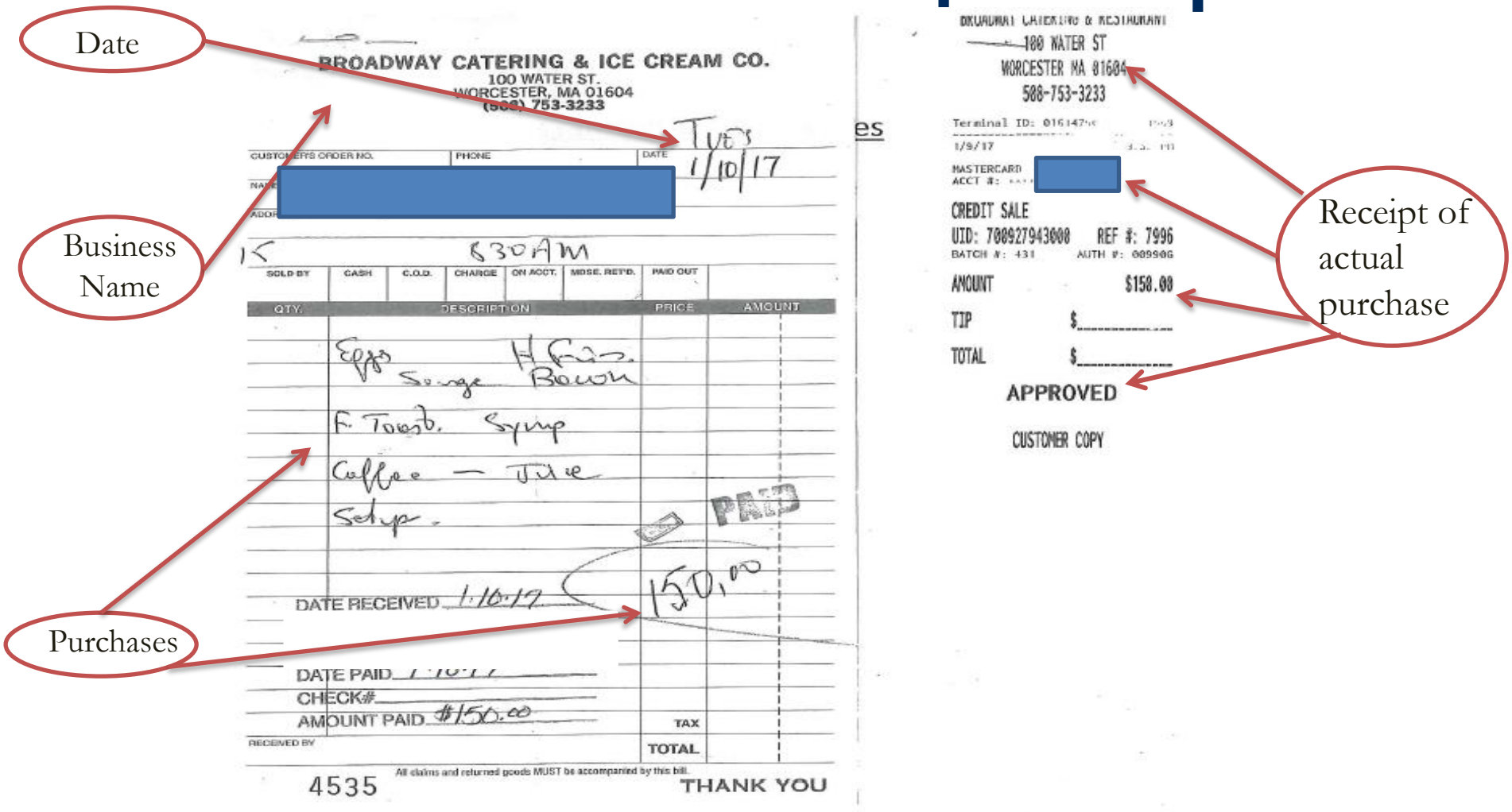
EMPLOYEE NAME / EMP ID S S NO.	RATE	HOURS	GROSS EARNINGS	FEDERAL EIC	OASDI MEDICARE	STATE SDI	LOCAL OTHER	TAXES DEDUCTS	NET PAY CHECK NO
[redacted]		80.00	3943.35	601.60	258.24	184.19	0.00	1104.42	0.00
	02/03/2017		4449.10	0.00	60.39	0.00	0.00	2838.93	DIRDEP
E 1 REGULAR	55.450	72.00	3992.40			D C1 CHECKING I		2825.83	
E H HOLIDAY	55.450	8.00	443.60			D GT GTL (OUT)		13.10	
E 1P MEDICAL $125			-183.95						
E 3H COST OF HEALT-M			735.78						
E GT GTL (IN) >$50			13.10						
E K1 403B EE			-221.80						
E MP MED FSA $125			-100.00						
[redacted]		80.00	3943.35	601.60	258.24	184.19	0.00	1104.42	0.00
	02/17/2017		4449.10	0.00	60.39	0.00	0.00	2838.93	DIRDEP
E 1 REGULAR	55.450	72.00	3992.40			D C1 CHECKING I		2825.83	
E O OTHER	55.450	8.00	443.60			D GT GTL (OUT)		13.10	
E 1P MEDICAL $125			-183.95						
E 3H COST OF HEALT-M			735.78						
E GT GTL (IN) >$50			13.10						
E K1 403B EE			-221.80						
E MP MED FSA $125			-100.00						
[redacted]		160.00	7886.70	1203.20	516.48	368.38	0.00	2208.84	0.00
			8898.20	0.00	120.78	0.00	0.00	5677.86	
E 1 REGULAR		144.00	7984.80			D C1 CHECKING I		5651.66	
E H HOLIDAY		8.00	443.60			D GT GTL (OUT)		26.20	
E O OTHER		8.00	443.60						
E 1P MEDICAL $125			-367.90						
E 3H COST OF HEALTH			1471.56						
E GT GTL (IN) >$50			26.20						
E K1 403B EE			-443.60						
E MP MED FSA $125			-200.00						

PAYCHEX INC. PHONE [redacted] FAX [redacted]

Invoice Backup: Other Direct Cost

- **<u>Meals/Client Food Line Item</u> Reimbursement Request:**
  - Must include a detailed receipt for
    - The type of food purchased
    - The purchase amount
    - The date of the purchase
  - Must include proof of payment
    - No reimbursement will be made without proof of payment
    - A bill may be submitted if the payment has been charged at the time of purchase
  - Food consumption must be related to program activities as described in your approved Scope of Service
  - Food Line item expenses must also be reasonable

Food Purchase Receipt Sample



Both of these and list of participant names must be submitted with request.

Invoice Backup: Other Direct Cost

- **<u>Staff Travel</u> Reimbursement Request:**
  - Must include a copy of the Travel Request Form with
    - The date and purpose of travel
    - The destination traveled (to and from information)
    - The signature of both the staff and the staff supervisor
  - Must include copies of parking and toll statements
  - Must include proof of payment
    - No reimbursement will be made without proof of payment
    - A bill may be submitted if the payment has been charged at the time of travel
  - Mileages for staff travel are reimbursed at $0.56/mile (IRS rate)

Staff Travel Sample

Required

Required

Required

STAFF MILEAGE EXPENSE FORM

DATE: [redacted]

NAME: [redacted] MILEAGE COST: $ [redacted]

PROGRAM: [redacted] AMOUNT: $51.74

Travel Dates	From Where to Where	Purpose of Travel	Number of Miles	Amount
11/8/16	[redacted]	[redacted]	22	$.11.10
11/16/16			6	$.3.00
11/21/16			6	$.3.00
11/25/16			17	$.8.50
11/28/16			22	$.11.10
11/29/16			6	$.3.00
11/30/16			6	$.3.00
11/30/16			8	4.04
11/30/16				5.00
TOTAL				$51.74

Requested By: [redacted]

Approved By: _____ Date: _____

Received By: _____ Date: _____

Staff Travel Sample

Ex: 1- Waybill

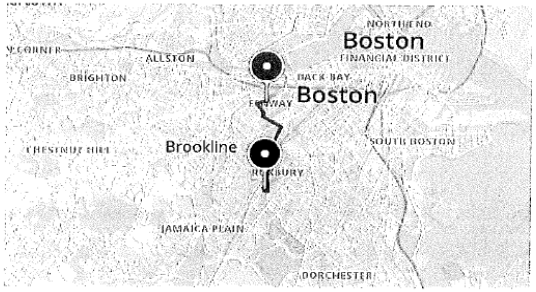
Thanks for r.

February 6, 2017 at 11:29 AM

Ride Details

Lyft fare (2.37mi, 11m 22s) $8.87

Discover * [redacted] **$8.87**



- Pickup 11:29 AM [redacted] Boston
- Dropoff 11:40 AM [redacted], Boston

Ex: 2 - Waybill

lyft

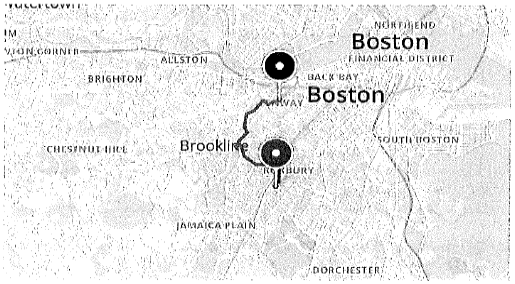
Thanks for riding

February 6, 2017 at 1:22 PM

Ride Details

Lyft fare (2.88mi, 15m 33s) $8.60

Discover * [redacted] **$8.60**



- Pickup 1:22 PM [redacted] St, Boston
- Dropoff 1:37 PM [redacted] Boston

Staff Travel Sample

IMPORTANT: Please provide this purchase order number when placing your order.
Vendors **MUST** include this purchase order number when billing AAC.

PURCHASE ORDER FORM

[redacted]

Today's date: 2/7/16 # 72937

[redacted]

Other approval: _____ PC Initials: [redacted]

Make check payable to (please print):

[redacted]

SS# _____

I will be using t[redacted]

Finance is to:

- [x] Cut a check - receipt or invoice is attached
- [ ] Wait for bill from vendor then pay
- [ ] Credit Card Charge

Purchase orders must be submitted by 3 p.m. on Friday to be included in Monday's check run.

Date	Purpose of Travel	From	To	Amount
2/6/2017	[redacted]	[redacted] Street, Boston	[redacted] Street, Boston	$ 8.60
2/6/2017	[redacted]	[redacted] h Street, Boston	[redacted] Street, Boston	$ 8.87

Total: $ 17.47

Put the check:

- [x] In my mailbox
- [ ] Mail it [ ] With attached form
- [ ] Give to:

Please note: unless indicated check will be mailed.

Finance use:

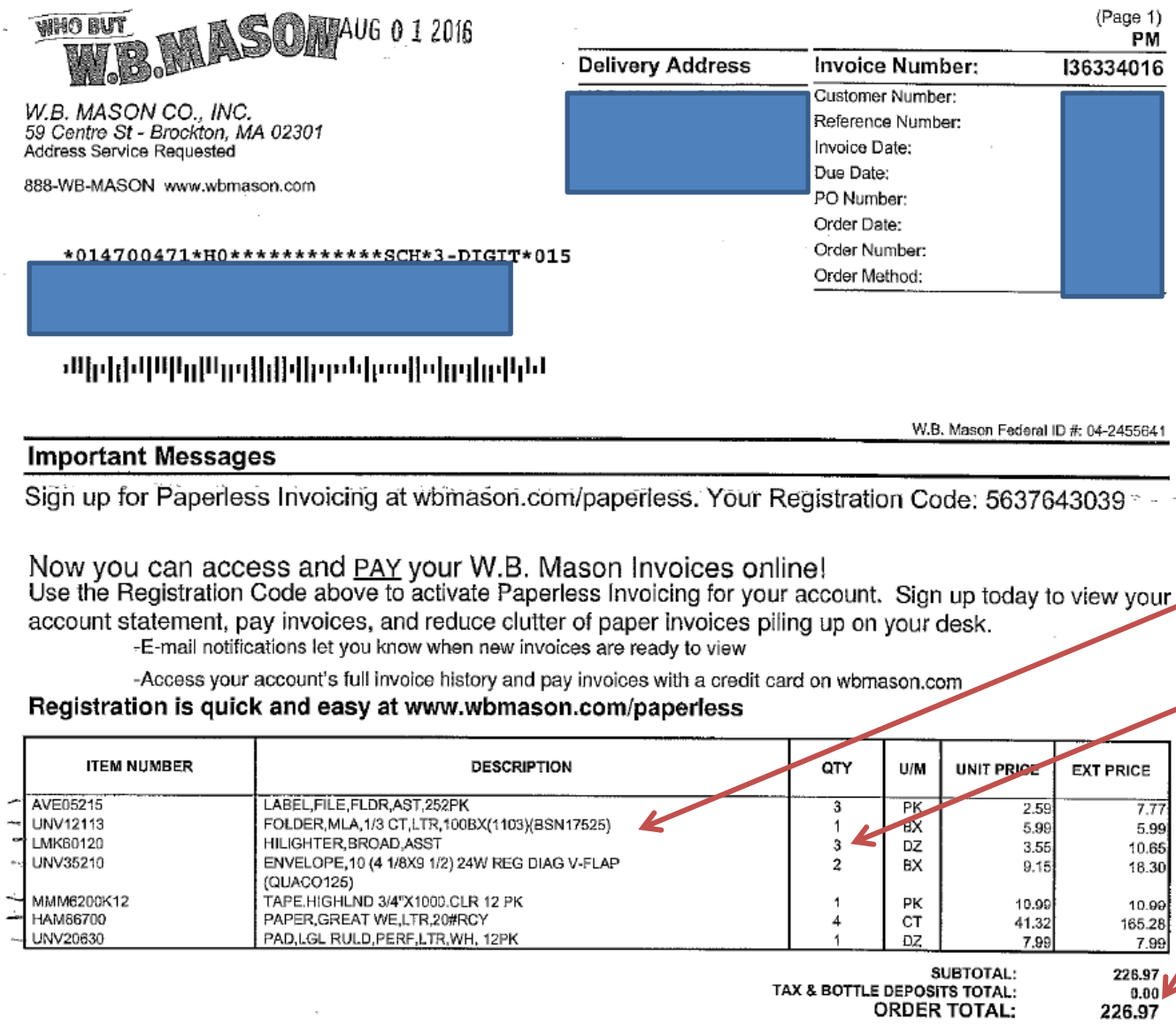
Vendor number	22277	Invoice amount	17.47
Description	[redacted]	Invoice number	72937
Invoice date	2/1/17	PO number	# 72937
Due date			

WHITE: - Give to Finance YELLOW: - To Staff

Invoice Backup: Other Direct Cost

- **<u>Program Supplies</u> Reimbursement Request:**
  - Must include a copy of the original vendor invoice
    - Description of purchased items
    - Total amount to be reimbursed
  - For split payments, the portion of E&O funding request for payment must be clearly labeled
  - Must include proof of payment
    - No reimbursement will be made without proof of payment
    - A bill may be submitted if the payment has been charged at the time of purchased
    - No tax payments are allowed under this funding

Program Supplies Receipt Sample



WHO BUT W.B.MASON AUG 0 1 2016

(Page 1)
PM

W.B. MASON CO., INC.
59 Centre St - Brockton, MA 02301
Address Service Requested

888-WB-MASON www.wbmason.com

*014700471*H0**********SCH*3-DIGIT*015

[redacted]

Delivery Address

[redacted]

Invoice Number: I36334016
Customer Number:
Reference Number:
Invoice Date:
Due Date:
PO Number:
Order Date:
Order Number:
Order Method:

[redacted]

W.B. Mason Federal ID #: 04-2455641

Important Messages

Sign up for Paperless Invoicing at wbmason.com/paperless. Your Registration Code: 5637643039

Now you can access and PAY your W.B. Mason Invoices online!
Use the Registration Code above to activate Paperless Invoicing for your account. Sign up today to view your account statement, pay invoices, and reduce clutter of paper invoices piling up on your desk.

-E-mail notifications let you know when new invoices are ready to view

-Access your account's full invoice history and pay invoices with a credit card on wbmason.com

Registration is quick and easy at www.wbmason.com/paperless

ITEM NUMBER	DESCRIPTION	QTY	U/M	UNIT PRICE	EXT PRICE
AVE05215	LABEL,FILE,FLDR,AST,252PK	3	PK	2.59	7.77
UNV12113	FOLDER,MLA,1/3 CT,LTR,100BX(1103)(BSN17525)	1	BX	5.99	5.99
LMK60120	HILIGHTER,BROAD,ASST	3	DZ	3.55	10.65
UNV35210	ENVELOPE,10 (4 1/8X9 1/2) 24W REG DIAG V-FLAP (QUACO125)	2	BX	9.15	18.30
MMM6200K12	TAPE,HIGHLND 3/4"X1000,CLR 12 PK	1	PK	10.99	10.99
HAM66700	PAPER,GREAT WE,LTR,20#RCY	4	CT	41.32	165.28
UNV20630	PAD,LGL RULD,PERF,LTR,WH, 12PK	1	DZ	7.99	7.99

SUBTOTAL: 226.97
TAX & BOTTLE DEPOSITS TOTAL: 0.00
ORDER TOTAL: 226.97

Receipt should include:
-Description of items
- Quantity
- Amount for reimbursement

Proof of Payment

[redacted]

8/22/2016 4:08:10PM

Page 7

Invoice Expense Allocation Report

CC

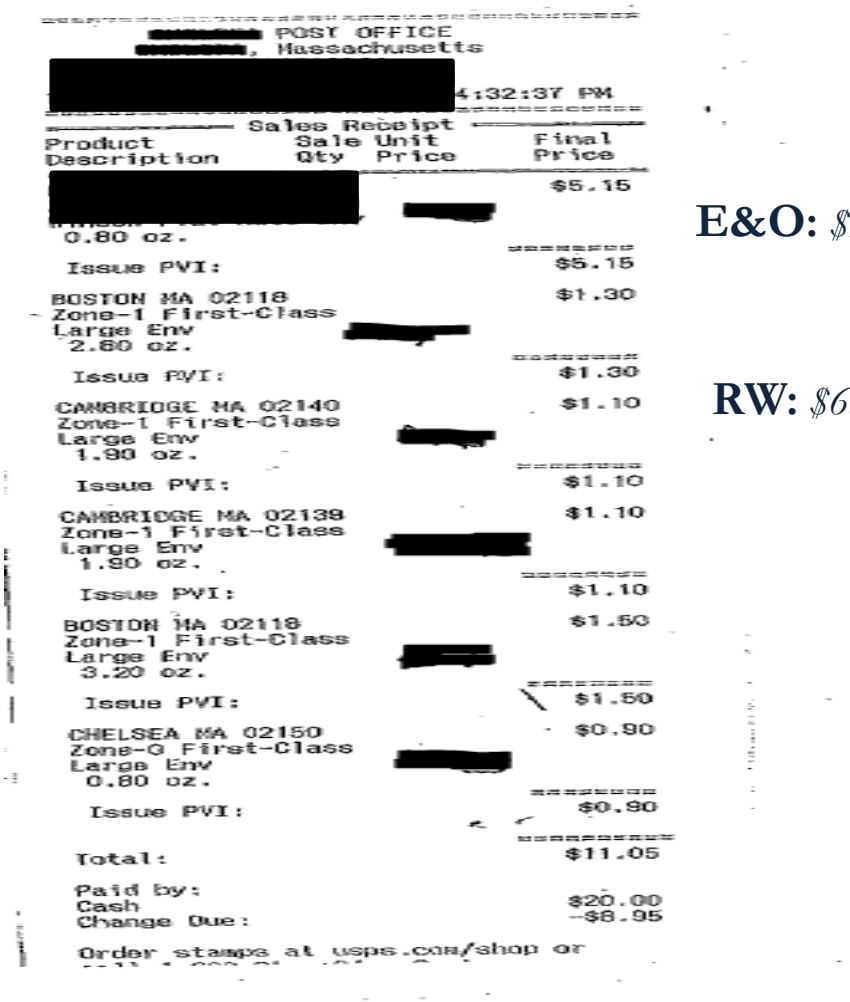
Vendor Name / Tax Identification Number	Transaction Date / Transaction Number	Description / Transaction Type	Status	Account Number	Account Description	Amount
W B Mason Co Inc						
I36334016						
W B Mason Co Inc XX-XXX5641	7/26/2016 I36334016	[redacted] Invoice	 Approved	1-53010	Office Supplies	$226.97

Project ID	Project Description	Amount
63100	E&O	$226.97

Totals for I36334016: $226.97

Totals for W B Mason Co Inc: $226.97

Split Supplies Payment Receipt Sample



[redacted] POST OFFICE
[redacted], Massachusetts
[redacted] 4:32:37 PM

Sales Receipt

Product Description	Sale Unit Qty	Price	Final Price
[redacted]			$5.15
0.80 oz.			
Issue PVI:			$5.15
BOSTON MA 02118 Zone-1 First-Class Large Env 2.80 oz.			$1.30
Issue PVI:			$1.30
CAMBRIDGE MA 02140 Zone-1 First-Class Large Env 1.90 oz.			$1.10
Issue PVI:			$1.10
CAMBRIDGE MA 02139 Zone-1 First-Class Large Env 1.90 oz.			$1.10
Issue PVI:			$1.10
BOSTON MA 02118 Zone-1 First-Class Large Env 3.20 oz.			$1.50
Issue PVI:			$1.50
CHELSEA MA 02150 Zone-0 First-Class Large Env 0.80 oz.			$0.90
Issue PVI:			$0.90
Total:			$11.05
Paid by: Cash			$20.00
Change Due:			-$8.95

Order stamps at usps.com/shop or

E&O: *$5.00*

RW: *$6.05*

If you are splitting your supplies order among other grants, please list how much is being paid by the E&O funding and the other sources.

Invoice Backup: Other Direct Cost

- **Incentives Reimbursement Request:**
  - Must include a copy of the original vendor invoice
    - Description of purchased incentives
    - Total amount to be reimbursed
  - Must include proof of payment
    - No reimbursement will be made without proof of payment
    - A bill may be submitted if the payment has been charged at the time of purchased
    - No tax payments are allowed under this funding

Please note:

- Incentives are defined by the program's Scope of Service
- Cash Stipends are not allowed

Incentives Back up

Boston Community Health Center

122 Main Street

Boston, MA 02110

Date: 7/14/17

RE: Incentives for Work plan

TO: Jane Doe

FROM: John Doe

Program funds for FY2014 include incentives for program participants as outlined in our approved work plan. Participants will complete 3 hours of intervention and appropriated staff. Participants will receive a $20 Gift Card from Target.

Justification for incentives

GiftCard

Target GiftCard Order Invoice

Order Number:
Order Date: 07/18/12

Billing Address:

Shipping Address:

Attention(Sold to):
Phone(Sold to):
Guest Number:
External Reference Number:

Attention(Ship to): 1

Design	Quantity	Value	Subtotal
Wellness Puppy	50	$20.00	$1,000.00

Totals	GiftCards	50
	Shipping	$0.00
	Order	$1,000.00
	Due	$1,000.00

Your order will be shipped upon receipt of payment. If no payment is received within 30days, the order will be cancelled.
Please include the order number on all payments and mail to the address below. Thank you for your order!

The Target Business Card is the easiest and fastest way to pay for Target GiftCards. You'll receive regular savings on shipping costs and earn Target Rewards for every dollar you spend. To find out more, visit Target.com/targetbank.
Target GiftCards is a service mark of Target Brands, Inc.

For questions or to place your next order, contact us at 1-800-5GIFTS5,1-800-544-3875. Cards are not redeemable for cash or credit except where required by law. For balance information or to report a lost, stolen or damaged card, call 1-800-544-2943. We can replace the remaining value on a lost, stolen or damaged card with the original purchase receipt.

Returns or exchanges must be made within 90 days of purchase and are subject to a 10% restocking fee unless prohibited by law. For additional details and return procedures, call 1-800-5GIFTS5. All GiftCards are deemed purchased in and issued from the State of Minnesota.

Target GiftCard Team * Mail Stop TFS 2B-H * 3701 Wayzata Blvd * Minneapolis, MN 55416

Phone: 1-800-5GIFTS5 * Fax: 1-800-440-4510 * e-mail: B2B.giftcards@target.com

Receipt for purchase of incentives

Invoice Payment Processes

Double checked for accuracy as it can create a delay in payment if elements are missing or are wrong.

Emailed invoices are reviewed and approved for payments by IDB Fiscal staff.

Approved invoices are then forwarded to Procure to Pay office for payments.

Monthly invoices containing all required information and back-up documentation are paid within 30 days of receipt.

Invoices are paid via ACH direct deposit only.

Invoice Submission

Invoices are sent via Email to:

Boston Public Health Commission

IDBinvoices@bphc.org

- Invoices **must be submitted by the 15th of every month** and are paid within 30 days of receipt.
- Agencies will receive a reminder email on the 16th if invoices are not received by the 15th.
- A non-compliance email/letter will be sent to all agencies for late invoice submissions.

Budget Revision

- Agencies may be allowed to shift funds between existing line items from their contract budgets via a **Budget Revision Request**

- **Budget Revisions** may be necessary due to the following:
  - Evolving service needs
  - Needs to use different means to accomplish the original agreed upon goals and objectives outlined in the Scope of Services

- In general, adding new other direct cost/line items to contract budgets is not an acceptable request

- Contract budgets may only be revised with the written approval of the Boston Public Health Commission, Education & Outreach Office, Senior Program Coordinator.

Budget Revision Submission

- Budget Revision requests including all required back-up documentation must be emailed to:

Greg M. Lanza,
Senior Program Coordinator
Education and Outreach
Community Engagement Division
Boston Public Health Commission
at

glanza@bphc.org

- The last day to submit a **Budget Revision** request to BPHC for FY 2022 is **April 1, 2022**

- Budget revisions after this deadline will only be made to fill vacant positions or to make title/name changes

Budget Revision Process

STEPS:

1. Agency emails a Budget Revision request packet to the Education & Outreach, Sr. Program Coordinator: **Greg Lanza**

2. If approved by the Sr. Program Coordinator, the request is submitted to the Bureau Director, **Dr. Sarimer Sanchez** for approval

3. If approved by the Bureau Director, the request is then submitted to our fiscal office to be processed by the Fiscal Manager: **Frantzsou Balthazar-Toussaint**

4. The completed budget revision request is then sent back to your Education & Outreach Sr. Program Coordinator, who prepares your approval packet

5. The approved packet is then emailed to the agency - Agency at that time is given the green light to bill BPHC/submit invoices using the Newly Revised Budget

6. If a revision request is denied, the agency will receive a denial letter – Appeal of denied budget revision requests are made in writing to the Sr. Program Coordinator: **Greg Lanza**

Budget Revision Documentation

Each Budget Revision request must include the following:

1. A Budget Revision Request Form (See FY22 Provider Manual)

A Budget Revision Request Form – A form that agencies must complete to outlines each change being proposed and how it will support the agency in achieving the funded service goals and objectives

2. A Budget Revision Excel Form

A current budget with the proposed changes made in the same format as the award budget. The proposed changes should be listed to the right of each personnel and/or other direct cost line items in the excel template. If the budget revision does not match the most up to date award budget, it will be returned to the agency (FY 2022 Provider Manual)

1. Supporting Documents

For new hires, provide:

- ❑A resume showing qualifications
- ❑Proof of annual salary such as an offer letter or payroll statement
- ❑Brief description of the position's duties and responsibilities as they relate to the funding

Budget Revision Exceptions

A **formal** Budget Revision request **is not needed** if the following is true:

- The request is to replace a TBD/TBH line with the name of a new employee at the SAME salary, FTE, and months that was originally proposed
- If moving expenses 10% or less from line to line
- If changing the title of an employee while leaving everything else the same

If any of the above exceptions apply, an agency only needs to submit the **Budget Revision Request** form to justify your proposed request with the necessary supporting documentation.

Budget Revision Request Form

BOSTON PUBLIC HEALTH COMMISSION

Community Engagement Division/Education & Outreach
Budget Revision Request Form
Fiscal Year 2022

Agency	
Service Category	
Date of Request	
Is the Budget Revision a resubmission?	☐ Yes ☐ No

For BPHC Use Only	**Date**	**Initial**
Program Review/Approval		
Bureau Direct Approval		
Fiscal Processing		
Approval Letter Sent		

1. **Change of Position, FTE, Salary, and Titles:** Include only the adjustment, removal, or addition of employee. Complete the Budget Revision Excel Form to account for financial adjustments. **Do not include additional lines created from line-item splits in the excel document on this form. Check yes to indicate a line was split for the respective position.**

Line Split	Start	End	Position	Personnel Name	Reason for Change
☐ Yes ☐ No					
☐ Yes ☐ No					
☐ Yes ☐ No					
☐ Yes ☐ No					

Budget Revision Request Form

2. **Changes of Other Direct Cost or Administrative Cost:** Include any budgetary adjustments.

Line Item	Current Budget	New Budget	Reason for Change

3. **Supporting Document:** Check yes for supporting documents attached with this form.

Attachment	Document Type	Comments
☐ Yes	**Offer Letter**	
☐ Yes	**Job Description**	
☐ Yes	**Resume**	
☐ Yes	**Quotes or estimates**	
☐ Yes	**Vendor Description**	
☐ Yes	**Payroll Forms**	
☐ Yes	**HHS Negotiated Rate**	
☐ Yes	**Other:** _____	
☐ Yes	**Other:** _____	
☐ Yes	**Other:** _____	
☐ Yes	**Other:** _____	

Budget Revision Request Form

4. **Signatures:** Sign this document by completing the section below.

Name of Authorized Representative	
Title	
Email	
Signature	

For BPHC use only:

Sr. Program Coordinator Review Comments	
Bureau Director Review Comments	
Fiscal Review Comments	

Budget Revision Excel Form

Boston Public Health Commission
Community Based Prevention
FY 2022
July 1, 2021- June 30, 2022
(Agency Name)
Education & Outreach

EXAMPLE

Budget Revision Request

Direct Cost	Personnel	Salary	FTE	Mos	Annual	Change	New Salary	New FTE	New Mos	New Annual	
Program Coordinator	Jones	$35,000	0.75	12	$26,250	($19,688)	$35,000	0.75	3	$6,563	Prior staff
	Valdez					$22,313	$35,000	0.85	9	$22,313	New staff
Program Coordinator	Davis	$32,000	1.00	12	$32,000	($2,560)	$32,000	0.92	12	$29,440	Current
Peer Leader	Brown	$25,000	0.25	12	$6,250	$0	$25,000	0.25	12	$6,250	
	SUBTOTAL		2.00		$64,500		**SUBTOTAL**	2.77		$64,565	
	FRINGE		29.30%		$18,899		**FRINGE**	29.30%		$18,918	
	PERSONNEL TOTAL				$83,399		**PERSONNEL TOTAL**			$83,483	
Other Direct Cost											
Office Supplies					$1,000	($84)				$916	
Educational Supplies					$200	$0				$200	
Food					$500	$0				$500	
	SUBTOTAL				$1,700		**SUBTOTAL**			$1,616	
	DIRECT COST TOTAL				$85,099		**DIRECT COST TOTAL**			$85,099	
HHS Indirect Approved Rate			**69.50%**		**Annual**						
BPHC Community Based Prevention Indirect Cap			12%		$10,212	$0		12.00%		$10,212	
	INDIRECT SUBTOTAL				$10,212		**INDIRECT SUBTOTAL**			$10,212	
		DIRECT COST TOTAL			$85,099	$0				$85,099	
		INDIRECT COST TOTAL (12% Cap)			$10,212	$0				$10,212	
		E&O SERVICE AWARD TOTAL			**$95,310**	$0				**$95,310**	

Current Budget **Proposed Budget**

Budget Revision Example

In this example, Program Coordinator Jones has left the agency after 3 months on the E&O contract. Program Coordinator Valdez has replaced Jones for the remaining 9 months of the fiscal year. The agency has decided to raise the new Program Coordinator's FTE from .75 to .85 on the contract. In order to cover the additional dollars, the agency had to reduce Program Coordinator Davis's FTE from 1.0 to .92 and remove $84 dollars from their Office Supplies line to put into the new Program Coordinator's line. The agency's original budget is reflected in the first six columns. Items and staff names may be added if new staff has been hired. For example, a new line has been inserted to reflect the hiring of Program coordinator Valdez.

Following are terms related to budget revisions. "Change" is the difference between the Annual and the New Annual (Change = Annual - New Annual). "New Salary" is the Full Time Equivalent (1 FTE total) salary. If there is a salary adjustment from the original "Salary," back-up documentation is required (e.g., hire letter). "New FTE" is the new percentage of time that the position listed will be paid through this contract. "New Months" indicates the new number of months that the employee will work; the number would differ from the original budget when a staff person is added or removed from a budget based on hiring or departure. "New Annual" is the updated total salary amount that will be paid for by Part A based on changes made to the salary, FTE, or months in the budget revision. "New Annual" for a staff member who is being removed from a budget must be the actual amount expended based on monthly invoices submitted to date.

Exercise

Questions?

Fiscal Team

Regis Jean-Marie, Bureau Administrator

Frantzsou Balthazar-Toussaint, Fiscal Manager

Monica Araujo, Fiscal Coordinator

Sheldon Ramdhanie, Fiscal Coordinator

Soane Monestime, Fiscal Coordinator