OMB #: 0584-xxxx
Expiration Date: xx/xx/20xx

EVALUATION OF DEMONSTRATIONS OF DIRECT CERTIFICATION OF CHILDREN RECEIVING MEDICAID BENEFITS (DC-M)

INSTRUCTIONS FOR TIME AND COST TRACKING LOG

DETAILED INSTRUCTIONS

TAB 1: Activity Descriptions. This tab provides more detailed descriptions of the activities to be considered/included when completing the Time Log (provided for clarification purposes). It also includes a glossary of terms. The State need not enter any information on this tab.

TAB 2: Time Log. In this tab, we are requesting information on the amount of time each staff member (or group of staff members with the same job category) spent on DC-M during the quarter, by activity. **Please include only time or costs incurred to implement DC-M that are in addition to time or costs already associated with other forms of direct certification for the National School Lunch Program/School Breakfast Program (that is, direct certification through the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, or Food Distribution Program on Indian Reservations).** Next, we provide instructions for completing each column.

***Column A: First Name, Initials, or Position of Staff Member*.** While tracking information on costs, we wish to minimize the amount of personally identifiable information included on the forms. Thus, if only a few staff members work on DC-M, we suggest listing them by first name or initials. If several staff members from a particular job category work on DC-M (such as programmers), they can be grouped on one line (assuming similar salary levels). Please include all staff members within your agency who worked on DC-M, even if the staff member was not specifically from the child nutrition division (for example, IT staff).

Column B: Staff Position. Please provide a descriptive job title for the person listed in Column A, unless he or she was listed by job title there.

Column C: Activity. Clicking on a cell in Column C will display an arrow on the right that opens a drop-down list of activities. Click on the appropriate activity to select it. The Activity Descriptions tab (TAB 1) provides more detailed definitions of the activities. If an activity that was part of DC-M is not listed, click on "Other activities" and describe the activity in Column G (Notes).

Columns D–F: Total Hours Spent in Month: July, August, September. For the person or persons listed in the row and the activity selected in Column C, enter the total hours spent on that activity in July, August, and September. If needed, please consult records or speak to the individual(s) or their supervisor. The staff members' best estimates are fine. To facilitate tracking, we have included a weekly version of the time log for state agencies to use if interested (see **TAB 7: Time Log – Optional Weekly Version**). In future quarters, we will provide you with a revised form early in the quarter that you can use to track costs as they occur, rather than retrospectively.

Column G: Notes. This column is for recording any additional details needed to understand the entries in Columns A–F.

TAB 3: Salary Information. In this tab, we are requesting information on the salaries of each staff member (or group of staff members with the same job category) who spent time related to the implementation of DC-M during the quarter. Next, we provide instructions for completing each column.

***Column A: First Name, Initials, or Position of Staff Member, and Column B: Staff Position*.** Please complete these columns for each staff member (or group of staff members with similar positions and salaries) who conducted DC-M activities, as you did in Tab 1. As with the time log, please include all staff members within your agency who worked on DC-M

Column C: Pay Rate (dollars). Please enter the dollar amount that the employee is paid for the time period described in Column D.

Column D: Basis Paid. Please specify (using the drop-down menu) whether the pay rate in dollars refers to dollars per hour, per week, twice per month (24 pay periods), bi-weekly (26 pay periods), per month, or per year. If the pay rate is in a different unit than one of these options, please explain in the Notes column. If the staff member received overtime pay, list that rate on a separate line and write "overtime" in the Notes column.

Column E: Fringe Benefit Rate/Amount. If fringe benefits are calculated as a percentage (such as 50 percent of salary), please enter the rate in this column. If fringe benefits are calculated as an amount, please enter the total dollar amount for the staff member(s) in the column. The dollar amount should reflect the same period as the base pay rate.

Column F: Percentage or Amount. Please specify (using the drop-down menu) whether the fringe benefits in Column E are expressed as a percentage or a dollar amount.

Column G: Notes. This column is for recording any additional details needed to understand the entries in Columns A–F.

TAB 4: Other Direct Cost (ODC) Information. In this tab, we are requesting information on any type of nonlabor ("other") direct costs (ODCs) that are incurred in order to implement DC-M. These may include printing and mailing costs for materials provided to school districts, charges for conference calls, or amounts paid to outside contractors for work on the project (such as programming or clerical work). Column A asks for the type of cost, Column B asks for the total dollar amount for the quarter, and Column C provides space for any explanatory notes. If totals by month are easier to report, please record them in the Notes column. If there are no ODCs related to DC-M, just type "no costs" somewhere on the form so we know it was not missed.

TAB 5: Indirect Cost Information. This tab (row 11) asks if the agency uses an indirect cost rate. If the answer is no, you do not need to provide any further information. If the answer is yes, please list the indirect cost rate and explain in row 12 what costs are included in indirect costs and how they are allocated. If there are differing indirect cost rates, depending on the cost to which it is applied, please provide detailed information on how each is allocated. Then, please estimate in row 13 the total indirect costs associated with the direct costs previously reported.

TAB 6: Contact Information. Please provide the requested information on how to contact the person responsible for completing this form (the person who will be the designated contact for further questions and for the follow-up interview). If multiple individuals contributed to the form, please provide this information for the major contributors.

Appendix B.1: Cost Survey Tracking Log (Child Nutrition Agency Version)

NSLP/SBP Direct Certification of Children Receiving Medicaid Benefits

Time Tracking Log

[*STATE NAME*] Child Nutrition Agency Version (July - September 2013)

OMB #: 0584-XXXX

Expiration Date: XX/XX/20XX

DC-M1/DC-M2:	
Name:	
Position/Title:	
Name of Agency/Division:	

First Name, Initials, or Position of Staff Member	Staffing Position (*if not specified in first column*)	Activity (select from list)	*Total Hours Spent During Month*			Notes
			July	August	September	
		[select from list]				
		[select from list]				
		[select from list]				
		[select from list]				
		[select from list]				
		[select from list]				
		[select from list]				
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		[select from list]				
		[select from list]				
		[select from list]				
		[select from list]				
		[select from list]				

Note: In this time log, please only include time incurred to implement DC-M that is *in addition to* time already associated with other forms of direct certification for school meals (such as direct certification through SNAP, TANF, or other programs).

Appendix B.1: Cost Survey Tracking Log (Child Nutrition Agency Version)

NSLP/SBP Direct Certification of Children Receiving Medicaid Benefits
Salary Worksheet
[*STATE NAME*] Child Nutrition Agency Version (July - September 2013)

OMB #: 0584- XXXX
Expiration Date: XX/XX/20XX

DC- M1/DC- M2:	
Name:	
Position/Title:	
Name of Agency/Division:	

First Name, Initials, or Position of Staff Member (include each staff listed in Time Log)	Staffing Position (*if not specified in first column*)	Pay Rate (dollars)	Basis Paid (select from list)	Fringe Benefit Percentage/ Amount	Fringe Benefits Calculated as:	Notes
			[select from list]		[select from list]	
			[select from list]		[select from list]	
			[select from list]		[select from list]	
			[select from list]		[select from list]	
			[select from list]		[select from list]	
			[select from list]		[select from list]	
			[select from list]		[select from list]	
			[select from list]		[select from list]	
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			[select from list]		[select from list]	
			[select from list]		[select from list]	
			[select from list]		[select from list]	
			[select from list]		[select from list]	

NSLP/SBP Direct Certification of Children Receiving Medicaid Benefits
Contact Information for Individuals Responsible for Completing Form
[*STATE NAME*] Child Nutrition Agency Version (July - September 2013)

OMB #: 0584- XXXX
Expiration Date: XX/XX/20XX

Name of Agency/Division:	
Address:	
City/State/Zip code:	
Name of Agency/Division #2 (if applicable):	
Address #2 (if applicable):	
City/State/Zip code #2 (if applicable):	
Name of 1st Contact Person:	
Phone Number for 1st Contact:	
Email Address for 1st Contact:	
Name of 2nd Contact Person (optional):	
Phone Number for 2nd Contact (optional):	
Email Address for 2nd Contact: (optional):	

Thank you for completing this form. Your responses will help us determine whether there are savings in administrative costs from the demonstration, and what the extent of the savings is. Your responses will also help us understand the various types of activities you perform when conducting direct certification. We understand that this task requires the investment of your time and greatly appreciate your participation. While we have tried to make these forms both flexible and straightforward, we will appreciate any suggestions for improvements. Please contact Anne Gordon (agordon@mathematica- mpr.com) or Joshua Leftin (jleftin@mathematica- mpr.com) with any questions.

Appendix B.1: Cost Survey Tracking Log (Child Nutrition Agency Version)

NSLP/SBP Direct Certification of Children Receiving Medicaid Benefits
Time Tracking Log
[*STATE NAME*] Child Nutrition Agency Version (July - September 2013)

OMB #: 0584- XXXX
Expiration Date: XX/XX/20XX

DC-M1/DC-M2:	
Name:	
Position/Title:	
Name of Agency/Division:	

First Name, Initials, or Position of Staff Member	Activity (select from list)	*Total Hours Spent During Week*													Notes
		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	
	[select from list]														
	[select from list]														
	[select from list]														
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	[select from list]														

Note: In this time log, please only include time incurred to implement DC-M that is *in addition to* time already associated with other forms of direct certification for school meals (such as direct certification through SNAP, TANF, or other programs).