

FY14 Part C Expenditures Report

| Section A: Identifying Information |
|---|
| ~ Enter Name of Grantee Here ~ |
| ~ Enter Grant Number Here ~ |
| ~ Enter Preparer's Name Here ~ |
| ~ Enter Preparer's Phone Number Here ~ |
| ~ Enter Preparer's Email Address Here ~ |

NOTE: Detailed instructions for completing and submitting your

| Section B: Reporting FY Award Information |
|---|
| 1. Part C Grant Award Amount |

| Section C: Expenditure Categories | REPORTING FY | | PRIOR FY CARRYOVER | | TOTAL | |
|--|--------------|---------|--------------------|---------|--------|---------|
| | Amount | Percent | Amount | Percent | Amount | Percent |
| 1. Core Medical Services Subtotal¹ (see CHECKLIST) | \$0 | 0% | \$0 | 0% | \$0 | 0% |
| a. Outpatient /Ambulatory Health Services | | -- | | -- | \$0 | -- |
| b. AIDS Drug Assistance Program (ADAP) Treatments | | -- | | -- | \$0 | -- |
| c. AIDS Pharmaceutical Assistance (local) | | -- | | -- | \$0 | -- |
| d. Oral Health Care | | -- | | -- | \$0 | -- |
| e. Health Insurance Premium & Cost Sharing Assistance | | -- | | -- | \$0 | -- |
| f. Home Health Care | | -- | | -- | \$0 | -- |
| g. Home and Community-based Health Services | | -- | | -- | \$0 | -- |
| h. Hospice Services | | -- | | -- | \$0 | -- |
| i. Mental Health Services | | -- | | -- | \$0 | -- |
| j. Medical Nutrition Therapy | | -- | | -- | \$0 | -- |
| k. Medical Case Management (including Treatment Adherence) | | -- | | -- | \$0 | -- |
| l. Substance Abuse Services - outpatient | | -- | | -- | \$0 | -- |
| 2. Support Services Subtotal | \$0 | 0% | \$0 | 0% | \$0 | 0% |
| a. Case Management (non-Medical) | | -- | | -- | \$0 | -- |
| b. Health Education/Risk Reduction | | -- | | -- | \$0 | -- |
| c. Linguistics Services | | -- | | -- | \$0 | -- |
| d. Medical Transportation Services | | -- | | -- | \$0 | -- |
| e. Outreach Services | | -- | | -- | \$0 | -- |
| f. Psychosocial Support Services | | -- | | -- | \$0 | -- |
| g. Referral for Health Care/Supportive Services | | -- | | -- | \$0 | -- |
| h. Rehabilitation Services | | -- | | -- | \$0 | -- |
| i. Respite Care | | -- | | -- | \$0 | -- |
| j. Treatment Adherence Counseling | | -- | | -- | \$0 | -- |
| 3. Total Service Expenditures | \$0 | -- | \$0 | -- | \$0 | -- |
| 4. Non-services Subtotal | \$0 | -- | \$0 | -- | \$0 | -- |
| a. Clinical Quality Management Activities ² (see CHECKLIST) | | -- | | -- | \$0 | -- |
| b. Grantee Administration ³ (see CHECKLIST) | | -- | | -- | \$0 | -- |
| 5. Total Expenditures (Service + Non-service) | \$0 | -- | \$0 | -- | \$0 | -- |

| |
|---|
| FOR OFFICE USE ONLY: |
| <input type="checkbox"/> Grantee received waiver for 75% core medical services requirement. |

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number. The OMB control number for this project is 0915-0318. Public reporting burden for this collection of information is estimated to be 5 hours per response. These estimates include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments to HRSA Reports Clearance Officer, Health Resources and Services Administration, Room 10-33, 5600 Fishers Lane, Rockville, MD. 20857.

Part C Expenditures Report Checklist

Please check the following before submitting your report!

- | | | |
|----------|--|--------------|
| 1 | 75% of your award must be spent on core medical services. After meeting the requirements below, this percentage should not be less than 75%. | -- |
| 2 | Clinical quality management must be at a reasonable level. | #REF! |
| 3 | You may not spend more than 10% on grantee administration. This percentage should not be more than 10%. | #REF! |

[NOTE: Detailed instructions for completing and submitting your report can be downloaded from the HR](#)