

**PROPOSAL FUNDING REQUEST**

**Adult Outpatient**

**Proposal Funding Request**

Amount Requested \_\_\_\_\_

**Other Funds to Augment Proposal**

| <u>Funding Source</u> | <u>Amount</u> |
|-----------------------|---------------|
| _____                 | \$ _____      |
| _____                 | \$ _____      |
| _____                 | \$ _____      |
| _____                 | \$ _____      |

**Unit Costs**

Based on the per unit reimbursement rate (unit= hour of service unless otherwise stated) for the services listed below, please indicate the number of hours of service for each service and the total number of patients that you plan to treat if awarded a contract with the county. **NOTE:** An Assessment is reimbursed on a per Assessment basis not on an hourly basis.

|                       | <u>Title XIX (Medicaid)</u> | <u>Low Income (County)</u> | <u># of Units</u> |
|-----------------------|-----------------------------|----------------------------|-------------------|
| Assessments:          | \$115.17                    | \$120.00                   | _____             |
| Individual Treatment: | \$77.04                     | \$78.00                    | _____             |
| Group Treatment:      | \$19.28                     | \$20.00                    | _____             |

Total Number of Individuals that you propose to serve: \_\_\_\_\_