

# Susan G. Komen For the Cure NC Triangle Affiliate

## Document 5: Budget Justification



Applicant Organization Name:	Project Director:
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**Please read the directions before filling out this form.**

- **Direct Costs:** The Komen NC Triangle Affiliate defines Direct Costs as those costs associated directly with the program. They list all categories listed on the budget excel sheet and budget justification forms except indirect costs.
- **If necessary, copy section pages if more rows are needed to list objectives etc. You need only list objectives by number in this section.**
- **Do not use a font smaller than 12pt.**

**A. Personnel/Salary: Must be specific to project and must be justified in narrative**

Name	Role on Project including goals and objectives	Type of Appointment (months)	Base Salary	Base Benefits	%Effort on Project	Salary Requested	Benefits Requested	Total Requested

**Personnel/Salary Justification:**

<b>1.Total personnel:</b>	\$
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**B. Supplies: Must be itemized by corresponding objective and category, all expenses greater than \$500.**

Objective #	Specific Activities	Purchased Materials for activity	Produced Materials for activity	Other (explain)	Justification	Amount Requested per activity

<b>2.Total supplies:</b>	\$
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**C. Equipment: Not to exceed 30% of direct costs; must be listed by corresponding objective and activity.**

Objective #	Activity	Type of equipment	Cost	Justification	Amount Requested

<b>3. Total Equipment cost</b>	\$
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**D. Travel and Transportation: Must itemize all including travel incentives and transportation costs. Mileage must be based on current federal mileage guidelines.**

Objective #	Activity	Justified Activity	Miles	Amount Requested

<b>4. Total Travel Cost:</b>	\$
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**E. Patient Care Costs: *Must itemize all including the following:***  
 Screening mammograms, diagnostic mammograms, CT Scans, MRIs, treatment costs, lymphedema supplies, other patient needs. It is essential to describe precisely what is included in the costs you quote. Must be listed by corresponding objective and activity.

Objective #	Objective Activity	Type of Service or Care	How many served?	Individual Cost	Total Cost

<b>5. Total Patient Care Costs:</b>	\$
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**F. Other Expenses:** Please do not include items that should be included in your direct costs. You can include food, program incentives and other items that will directly impact the success of your program.

Objective #	Objective Activity	Type of Expense	Justification	Requested

<b>6. Total Other Expenses:</b>	\$
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<b>7. SUBTOTAL: DIRECT COSTS (sum total of items 1-6 above)</b>	\$
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**G. Indirect Cost Allocation: Indirect costs that cannot be directly identified to a program or activity. Examples may include accounting salaries, rent or utilities. These can be no more than 10% of the direct costs.**

Direct Cost Total	% of Direct Cost requested for Indirect

<b>8. Indirect Cost Allocation Total:</b>	\$
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<b>TOTAL FUNDING REQUEST: Total of items 7 and 8</b>	\$
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