

**North Sound Behavioral Health Administrative Services Organization
 Dedicated Marijuana Account Program
 Cost Reimbursement Budget
 January 1, 2020 to June 30, 2020
 Island County Human Services**

Revenues

Dedicated Marijuana Account Funding	\$	35,489
Total	\$	<u>35,489</u>

Expenses

Dedicated Marijuana Account	\$	35,489
Total	\$	<u>35,489</u>

**North Sound Behavioral Health Administrative Services Organization
 Jail Services Program
 Cost Reimbursement Budget
 January 1, 2020 to June 30, 2020
 Island County Human Services**

Revenues

Jail Service Funding	\$	11,194.05
Total	\$	<u>11,194.05</u>

Expenses

Jail Service	\$	11,194.05
Total	\$	<u>11,194.05</u>

**North Sound Behavioral Health Administrative Services Organization
 Housing and Recovery Through Peer Services
 Cost Reimbursement Budget
 January 1, 2020 to June 30, 2020
 Island County Human Services**

Revenues

HARPS State Funds	\$	8,561.00
Total	\$	8,561.00

Expenses

HARPS Housing Vouchers	\$	8,561.00
Total	\$	8,561.00

**North Sound Behavioral Health Administrative Services Organization
 Substance Abuse Block Grant CFDA 93.959
 Cost Reimbursement Budget
 January 1, 2020 to June 30, 2020
 Island County Human Services**

Revenues

SABG Funds	\$	53,126.00
Additional SABG	\$	84,438.00
Total	\$	<u>137,564.00</u>

Expenses

Opiate Outreach Services	\$	53,126.00
Additional SABG	\$	84,438.00
Total	\$	<u>137,564.00</u>

North Sound Behavioral Health

Monthly Billing Form

Agency Name _____
 Program _____
 Period Covered _____

Expenses

Salaries & Wages	\$	-
Personnel Benefits	\$	-
Office & Operating Supplies	\$	-
Small Tool & Minor Equipment	\$	-
Professional Services	\$	-
Communications	\$	-
Travel	\$	-
Operating Rentals	\$	-
Insurance	\$	-
Utilities	\$	-
Repair & Maintenance	\$	-
Machinery & Equipment	\$	-
Miscellaneous Expense	\$	-
Capital	\$	-
Direct Cost Allocations	\$	-
Indirect Cost Allocations	\$	-
Other		
Total	\$	-

Vendor's Certificate. I hereby certify under penalty of perjury that the items and totals

Signature of Agency Representative _____
 Name of Agency Representative _____
 Date _____

Submit to fiscal@nsbhaso.org