COMMISSION ON MINORITY HEALTH

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GOVERNOR

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Miscellaneous Supplemental Grant

INTERIM REPORT From _____ to _____

Grant # MGS - Agency:

Federal Tax ID# Address:

Contact Person: Telephone Number:

1. Summarize the activities provided by your agency/organization.

   a. Provide an overview of the event planning to date, to include the time, date, location, speakers, and subject matter. If the event was held, was the event attended by the targeted racial and ethnic population(s)?

   Provide the number that was directly served. Please note, counting those in attendance at a larger event in which your organization is present, does NOT count towards your number served. Only participants who directly participate in your event.

b. Has the proposed outcome and/or quantifiable benefit that this endeavor will provide to the targeted communities changed? If so, why?
Please provide the proposed new outcomes for each event goal and their associated objectives. If proposed outcome and/or quantifiable benefits that this endeavor will provide to the targeted communities has not changed, please state, "Proposed outcomes and/or quantifiable benefits that this endeavor will provide to the targeted communities, has not changed.

c. List the counties served by the event. If the event has taken plance include the numbers of attendance from each county.

d. Did/Will you implement the event satisfaction survey? Yes ☐ No ☐

If not, what prevented you from doing so? If so, discuss the results of the satisfaction survey to include averaging of response scores and a list participant comments. Please add additional pages as necessary.

e. Please describe accomplishments to date, if event has taken place. If event has not taken place, please state, "Event has not yet taken place."

f. Please describe problems encountered and their solutions to include if there were any changes in the original program activity. If no problems were encountered, please provide a statement to that effect.

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2. Demographic Screening Reporting Form

☐ Event did not include screenings.

* PLEASE NOTE: ALL ABNORMAL SCREENS MUST RECEIVE FOLLOW UP. Each Grantee will be required to collect contact information on a sign in sheet to allow follow up for any abnormal screens as needed. Grantees should have community referral resources on hand for abnormal screenings

Screening Type (i.e., diabetes, cholesterol, hypertension, mammography, prostate)	Total No. screened (If event has taken place.)	Gender			**Total Abnormal Screenings ONLY**	Number of ***Abnormal*** Screenings by Ethnic\Racial Group*					
		Male	Female	Total		African American	Hispanic	Native American	Asian	White	Other
Ex: Diabetes	100	50	50	100	30	10	10	5	5	0	0

2. **Event / Education Demographics - If event has taken place.**

COMMUNITY PARTICIPATION							
Date(s) of Event(s) (list separately)	Total # served	Number served by Ethnic/Racial Group					
		African American	Hispanic	Native Am. Indian	Asian	White	Other

a) Date of event/Service Provided: Indicate each separate activity/service and the date on which it occurred.
b) Total # Served: Record the number of people served for each event/service period.
c) Total # by Ethnic/Racial Group: Record the number of African Americans, Asians, Hispanics and Native American Indians served through each service/event.

3. Marketing: Attach press releases, newspaper articles and materials developed with grant funds.

SUPPLEMENTAL GRANT EXPENDITURE REPORT - TO DATE

Agency Name: Grant #

Executive Director: Contact Person:

Federal Tax ID Number: Phone Number:

1. Under Column A list line items as they appear on the Approved Budget.

2. Under Column B list budgeted amounts Requested from Commission as they appear on the Approved Budget.

3. Under Column C list only expenditures to be reimbursed by the Commission.

4. Attach all appropriate receipts. Failure to submit receipts will result in non- reimbursement.

A	B	C
BUDGET CATEGORY	**AMOUNT REQUESTED FROM COMMISSION**	**AMOUNT EXPENDED TO DATE (Commission Funds Only)**
5. **Total Commission Cost**		

We certify the information contained in this report is to the best of our knowledge, correct and reflective of the agency's accounting records. **MUST BEAR ORIGINAL SIGNATURES in BLUE INK.**

_____ _____

Signature of Executive Director Date

_____ _____

Signature of Fiscal Officer Date

Instructions for Completion of the Supplemental Grant Expenditure Report

Agency Name: Insert the legal name of your agency. It must match the name on the 501 (C) 3.

MGS____-____: Your supplemental grant will receive a grant number when it arrives in the Commission office. The agency must use this number on all budget forms and use it whenever you correspond with the Commission.

Executive Director: Insert the name of the Chief Executive Officer of the applicant agency and official title.

Contact Person: Use the name of the person who has day-to-day responsibility for the Minority Health Month Project.

Federal Tax I.D.#: This number is issued by the IRS. It appears on agency's 501 (C)(3) or sometimes as the Entity Identification Number (EIN). The tax ID number must be the number representing the agency that is applying for grant funds. If an applicant is using another agency's tax ID number, the agency whose number is being used will be reimbursed for expenditures made during the grant period.

Phone: Applicant should give the phone number of the contact person(s) who has day-to-day responsibility for the Minority Health Month project.

NOTES:

- **All expenditures must be supported by copies of receipts. For speakers copies of canceled checks are acceptable. Failure to submit supporting documentation will result in non-reimbursement**.
- **Items listed as expenditures that do not appear on the approved budget will be disallowed.**

Speakers

Column A: Identify each speaker (by name) whose speaking fee will be paid for by the Commission. List topic(s) as well.
Column B: Identify the amount listed in the APPROVED BUDGET under Column B.
Column C: Enter the expended amount to be reimbursed by the Commission. The amount identified cannot exceed the amount listed in Column B of the approved budget.

Rentals

Column A: Specify each rented line item with unit cost charged to the Commission (rental of chairs, tables, rooms, etc.), e.g. 50 chairs x .80/chair = $40.
Column B: Specify the cost of the rented line item being charged to the Commission. The amount listed should be the same amount identified in the APPROVED BUDGET under Column B.
Column C: Enter the amount spent that you want to be reimbursed by the Commission. The amount identified cannot exceed the amount listed in Column B as it appears in the approved budget.

Supplies Contract & Other

Column A: Make a list of all supplies. They must be itemized and specify unit costs (e.g. office supplies, printing, advertising, etc..), and contracts (e.g.video service, printing etc.).
Column B: Identify the cost of each product or service being charged to the Commission. The amount should not exceed the amount that is listed in the approved budget under Column B.
Column C: Enter the amount that will be charged to the Commission. The amount identified cannot exceed the approved amount for the supplies Contract & Other category.

Total Commission Cost: Add up the dollar amounts in Column B and Column C. The amount in Column B should not exceed the approved budget. The amount in Column C is the amount you wish to be reimbursed by the Commission. The total amount **can not** exceed the amount stated in the Notice of Award and approved budget.

Executive Director and Fiscal Officer:

The Expenditure Report must be signed by the Executive Director and the Fiscal Officer. **Without their signature this report is invalid**