



**Department
of Health**

Budget Modifications

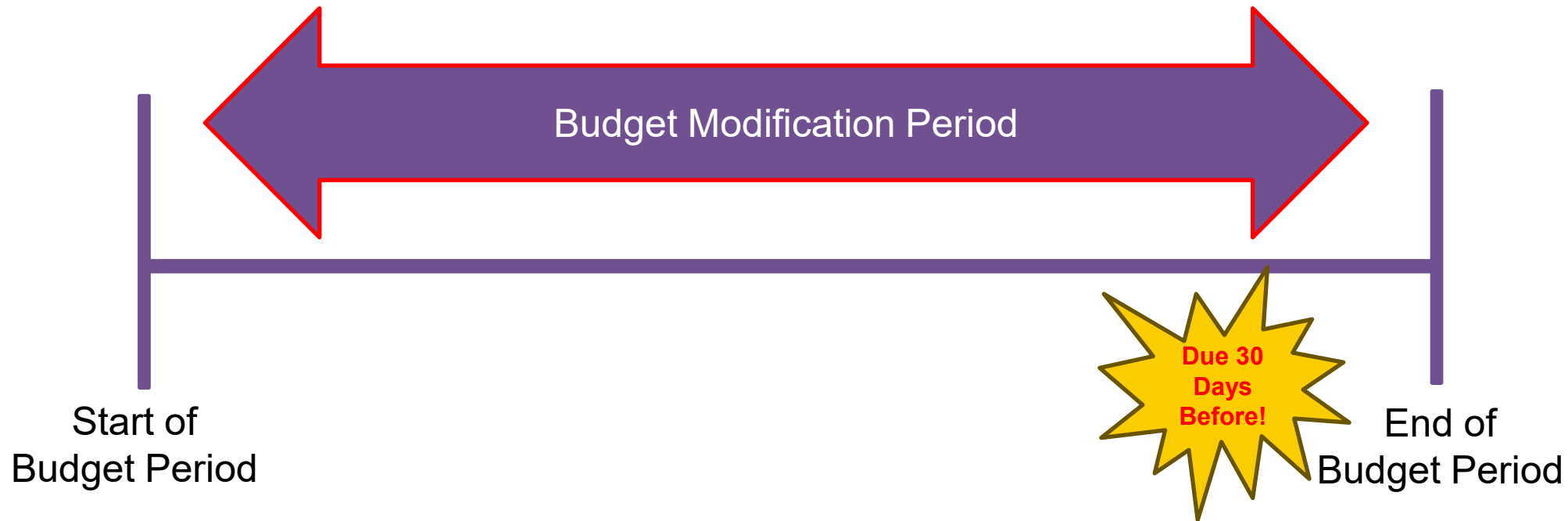
Extramural Grants Administration – Wadsworth Center

BUDGET MODIFICATION REQUESTS OVERVIEW

Requests are used to move funds between budget lines within a contract year.

- Due 30 days before the end of the budget period being modified
- Form must be submitted in Excel format
- DOH approval is required for all requests
- Office of the State Comptroller (OSC) approval *may also* be required
- Changes cannot jeopardize ability to complete research aims within a contract term

BUDGET MODIFICATION REQUESTS OVERVIEW



BUDGET MODIFICATION REQUEST OVERVIEW

Cover Page

The Cover Page Tab must be filled out in its entirety following the instructions on Slide 5 of this presentation.

Worksheet & Justification

The Worksheet & Justification Tab must be filled out in its entirety following the instructions on Slides 6-9 of this presentation.


PS Detail

The PS Detail Tab must be filled out in its entirety following the instructions on Slide 10 of this presentation.



Budget Modification Request – Cover Page

1. Enter Contract Number (CXXXXXXGG or GM)
2. Enter Contractor SFS Payee Name
3. Enter Contract Period enter in MM/DD/YY format
4. Select Funding Source (drop down list)
5. Enter Name of PI
6. Enter Name of Grants Official
7. A signature is not required on this form



BUDGET MODIFICATION REQUEST FORM

All budget line interchanges require DOH approval. Justification must be submitted on additional pages. Any modification that results in a cumulative change greater than or equal to 10 percent (for contracts less than \$5 million) or 5 percent (for contracts greater than \$5 million) of the total contract value between Personal Services and Non-Personal Services will be submitted to the Office of the State Comptroller for approval. This approval may take 3-4 months to obtain.
Form must be submitted in Excel format.

1 CONTRACT NUMBER:

2 CONTRACTOR SFS PAYEE NAME:

3 CONTRACT PERIOD:

4 FUNDING SOURCE:

5 PRINCIPLE INVESTIGATOR:

Name and Title

6 GRANTS OFFICIAL:

Name and Title

7 **ASSURANCES:** By submission of this document, the Principal Investigator, Grants Official and Organization attest that this information is true, accurate and complete to the best of their knowledge.

NOTE: SIGNATURES NOT REQUIRED

BUDGET MODIFICATION REQUEST WORKSHEET & JUSTIFICATION

BUDGET MODIFICATION REQUEST - WORKSHEET & JUSTIFICATION

1

Genetics:
genetic.counseling@health.ny.gov
HRSB:
HRSB@health.ny.gov
SCIRB:
SCIRB@health.ny.gov

CONTRACT NUMBER:

CONTRACT SFS PAYEE NAME:

CONTRACT PERIOD:

Justification: Explain the need for the proposed budget changes. Indicate whether these changes affect the specific aims of the project. If a category is reduced, describe how the project goals will still be met. Use additional pages, if necessary.

CATEGORY OF EXPENSE2	COLUMN I	3COLUMN II	4COLUMN III	5Justification
	CURRENT BUDGET	REQUESTED CHANGE	REVISED BUDGET	
1. PERSONAL SERVICES				<div>1. Header will populate from Cover Page.</div> <div>2. Enter budget line details based on the Names/Titles, etc. from the executed contract. Enter Current Budget in Column I, it must match most recently approved Attachment B-1 or B-1(A).</div> <div>3. Column II "Requested Change" is formula driven. DO NOT enter data in this column.</div> <div>4. Enter Revised Budget in Column III.</div> <div>5. See Tab 8 for additional information on entering your Budget Modification justification.</div>
a) SALARY	-	-	-	
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
b) FRINGE		-		
SUBTOTAL	-	-	-	
2. NON PERSONAL SERVICES				
a) CONTRACTUAL SERVICES	-	-	-	
Enter subcontractor name		-		
b) TRAVEL	-	-	-	
Travel		-		
Meeting Registration		-		
c) EQUIPMENT	-	-	-	
Enter Item Description		-		

BUDGET MODIFICATION REQUEST WORKSHEET & JUSTIFICATION

BUDGET MODIFICATION REQUEST - WORKSHEET & JUSTIFICATION

Genetics: genetic.counseling@ HRSB: HRSB@health.ny.gov SCIRB SCIRB@health.ny.gov	CONTRACT NUMBER:		
	CONTRACT SFS PAYEE NAME:		
	CONTRACT PERIOD:		
INCOMPLETE / INVALID REQUEST			
CATEGORY OF EXPENSE	COLUMN I	COLUMN II	COLUMN III
	CURRENT BUDGET	REQUESTED CHANGE	REVISED BUDGET
1. PERSONAL SERVICES			
a) SALARY	85,000.00	-	85,000.00
Principal Investigator - Dr. Doe	75,000.00	(10,000.00)	65,000.00
b) FRINGE	22,000.00	3,000.00	25,000.00
SUBTOTAL	107,000.00	3,000.00	110,000.00
2. NON PERSONAL SERVICES			
a) CONTRACTUAL SERVICES	-	-	-
SUBTOTAL	-	3,000.00	-
TOTAL	107,000.00	DOES NOT EQUAL ZERO	110,000.00

Please Do Not Overwrite Formulas Contained in this Worksheet.

Proposed Budget total Must Equal Approved Budget
Total and Sum to \$0.00!!

BUDGET MODIFICATION WORKSHEET & JUSTIFICATION

The revised Budget Modification form allows for the justification to be entered on the same page as the requested budget changes. To ensure your request is reviewed timely and to help alleviate additional questions, each budget line with a requested change amount must be justified in detail.

BUDGET MODIFICATION REQUEST - WORKSHEET & JUSTIFICATION

Genetics: genetic.counseling@health.ny.gov HRSB: HRSB@health.ny.gov SCIRB SCIRB@health.ny.gov	CONTRACT NUMBER:	0	Justification: Explain the need for the proposed budget changes. Indicate whether these changes affect the specific aims of the project. If a category is reduced, describe how the project goals will still be met. Use additional pages, if necessary.
	CONTRACT SFS PAYEE NAME:	0	
	CONTRACT PERIOD:	MM/DD/YY - MM/DD/YY	

SUBMIT

CATEGORY OF EXPENSE	COLUMN I	COLUMN II	COLUMN III	Justification
	CURRENT BUDGET	REQUESTED CHANGE	REVISED BUDGET	
1. PERSONAL SERVICES				
a) SALARY	-	-	-	
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
Enter Position Title From Contract		-		
b) FRINGE		-		
SUBTOTAL	-	-	-	

- Detailed Justification Must:
- Explain the proposed change(s)
 - Indicate whether change(s) affect(s) approved research aims
 - Describe how project goals will be met

BUDGET MODIFICATION WORKSHEET & JUSTIFICATION

Be Specific

- Strength of justification is *critical* to the approval of the request
- Justification must be tied to progress made on contracted research Aims
 - Progress to date on each specific aim
 - Plans for use of funds to accomplish stated aims

BUDGET MODIFICATION PERSONAL SERVICE DETAIL

BUDGET MODIFICATION REQUEST - PERSONAL SERVICE DETAIL								
1 Genetics: genetic.counseling@health.ny.gov HRSB: HRSB@health.ny.gov SCIRB SCIRB@health.ny.gov	CONTRACT NUMBER:							
	CONTRACT SFS PAYEE NAME:							
	CONTRACT PERIOD:							
2	POSITION TITLE	ANNUALIZED SALARY PER POSITION	STANDARD WORK WEEK (HOURS)	PERCENT OF EFFORT FUNDED	NUMBER OF MONTHS FUNDED	3 SALARY	BENEFIT RATE	4 FRINGE
						-		-
						-		-
						-		-
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						-		-
The values in the Salary & Fringe columns must match those of the BM Worksheet Column III Requested Budget.					Total Salary	-	Total Fringe	-

The salary column must match the column III requested in the CF worksheet tab.

1. Header will populate form Cover Page
2. Position Title must match that of the Worksheet
3. Salary will automatically calculate based on the information entered in (Annualized Salary, Percent Effort and Number of Months Funded).
4. Enter Benefit Rate (%) – Fringe will automatically calculate

Budget Modifications and OSC Approval

- Changes less than 10% of the total contract budget require DOH approval
- Changes greater than 10% of the total contract budget require OSC approval
- 10% is cumulative over the contract term
- Please limit requests to one modification per budget year. Excessive requests will not be approved.
- Fewer modifications = fewer delays in the approval process

Approval Notification

- Less than 10% of the total contract budget:
 - EGA approval letter
- More than 10% of the total contract budget:
 - EGA approval letter with contingencies

Any Questions?

Contact us at:

hrrb@health.ny.gov

scirb@health.ny.gov

genetics@health.ny.gov

or

(518) 474-7002



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