

**BUDGET REQUEST FORM
LA CROSSE COUNTY HUMAN SERVICES DEPARTMENT
FACE SHEET**

Agency Name: _____	
Type of Agency: ___ Non-Profit &/or Governmental Agency ___ Hospitals/Clinics ___ For-Profit	
Fiscal Year: _____ through _____	
Person to Contact with _____	
Budget Questions: _____	
Name of Agency _____	
Administrator: _____	
Agency Phone Number: _____	
Service(s): _____	
License Capacity(if applicable): _____	_____
Agency Hours of Operation _____	_____
_____	_____

PER UNIT COST CALCULATION

Program Name _____

	<u>Program 1</u>	<u>Program 2</u>
Total Expenses from Page 3	_____	_____
(Less): Cost Offsets*	_____	_____
_____	_____	_____
_____	_____	_____
(=) Adjusted Total Expenses	_____	_____
(+) Profit **	_____	_____
(=) Allowable Costs	_____	_____
(divided by) Units of Care	_____	_____
(=) Cost per Unit	_____	_____
Identify Type of Unit (i.e. per day, hour)***	_____	_____

*Cost Offsets include things such as in-kind *staff meals, different county funding, revenues, USDA funding, United Way Contributions, etc.*

**FOR PROFIT AGENCIES ONLY! – Please refer to Page 4 to calculate.

***On a separate piece of paper, describe in detail your unit type – definition, proposed number of units, calculation as to how you arrived at this number of units, etc.