The University of the State of New York
THE STATE EDUCATION DEPARTMENT

PROPOSED BUDGET FOR A FEDERAL OR STATE PROJECT FS-10 (03/15)

= Required Field

Local Agency Information

Funding Source:	CRRSA GEER 2- Gov. Ed. Emer. Rlf.- 5896-21	
Report Prepared By:	Beth S. Lamb	
Agency Name:	Stockbridge Valley C. S.	
Mailing Address:	P.O. Box 732	
	Street	
	Munnsville, NY 13409	
	City State Zip Code	
Telephone # of Report Preparer:	315-495-4446	**County:** Madison
E-mail Address:	blamb@stockbridgevalley.org	

Project Funding Dates: 3/13/2020 (Start) 9/30/2023 (End)

INSTRUCTIONS

- Submit the original FS-10 Budget and the required number of copies along with the completed application directly to the appropriate State Education Department office as indicated in the application instructions for the grant program for which you are applying. DO NOT submit this form to Grants Finance.
- The Chief Administrator's Certification on the Budget Summary worksheet must be signed by the agency's Chief Administrative Officer or properly authorized designee.
- An approved copy of the FS-10 Budget will be returned to the contact person noted above. A window envelope will be used; please make sure that the contact information is accurate and confined to the address field without altering the formatting.
- For information on budgeting refer to the Fiscal Guidelines for Federal and State Aided Grants at http://www.oms.nysed.gov/cafe/guidance/.

PURCHASED SERVICES WITH BOCES			
		Subtotal - Code 49	$19,558
Description of Services	Name of BOCES	Calculation of Cost	Proposed Expenditure
Pre-K Early Childhood Education Services	Madison-Oneida BOCES	Total Program Cost- $363,715	$19,558

BUDGET SUMMARY

SUBTOTAL	CODE	PROJECT COSTS
Professional Salaries	15	
Support Staff Salaries	16	
Purchased Services	40	
Supplies and Materials	45	
Travel Expenses	46	
Employee Benefits	80	
Indirect Cost	90	
BOCES Services	49	$19,558
Minor Remodeling	30	
Equipment	20	
Grand Total		$19,558

Agency Code: **251501040000**

Project #: **5896-21-XXXX**

Contract #:

Agency Name: Stockbridge Valley C. S.

CHIEF ADMINISTRATOR'S CERTIFICATION

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements, and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal (or State) award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative penalties for fraud, false statements, false claims, or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

6/4/2021 (Date) Dr. Vickers (Signature)

Dr. Susan Vickers- Interim Superintendent

Name and Title of Chief Administrative Officer

FOR DEPARTMENT USE ONLY

Funding Dates: _____ From _____ To

Program Approval: _____ Date: _____

Fiscal Year	First Payment	Line #

Voucher # _____ First Payment _____

Finance: Logged _____ Approved _____ MIR _____