

Boone, Campbell & Kenton County MH/MR/Aging Funds
Monthly Program Report

KENTON COUNTY

WAYNE SPEIGEL
KENTON CO. FISCAL COURT
P.O. BOX 792
COVINGTON, KY 41012

CAMPBELL COUNTY

PAT DRESSMAN
CAMPBELL CO FISCAL COURT
P.O. BOX 340
NEWPORT, KY 41071

BOONE COUNTY

KIRK KAVANAUGH
BOONE CO. HUMAN SERVICES
P.O. BOX 296
BURLINGTON, KY 41005

For the month of: _____
Name of Service: _____

Service Provider: _____
Phone: _____

Unduplicated Clients

PLANNED CLIENTS

CLIENTS SERVED

Monthly

Year-to-Date

	PLANNED CLIENTS			Monthly		CLIENTS SERVED		TOTAL
	With County Tax Funds	Non-County Tax Funds	TOTAL	County Tax Funds	Non-County Tax Funds	County Tax Funds	Non-County Tax Funds	
Boone								
Campbell								
Kenton								
All other Counties								

Unit of Service

PLANNED UNITS

UNITS PROVIDED

Monthly

Year-to-Date

	PLANNED UNITS			Monthly		UNITS PROVIDED		TOTAL
	With County Tax Funds	Non-County Tax Funds	TOTAL	County Tax Funds	Non-County Tax Funds	County Tax Funds	Non-County Tax Funds	
Boone								
Campbell								
Kenton								
All other Counties								

	Annual Budget Amount	Current Month's Expenditures	Expenditures Year-To-Date	Balance After Year-To-Date Expenditures	Amount Received To Date
Boone Aging/MH/MR					
Campbell Aging/MH/MR					
Kenton Aging/MH/MR					
Other Funds					
TOTAL					

Amount of other funds applied to:

	Monthly		Year-To-Date		Cost Per Unit of Service	
					County Only	Total
Boone	\$ _____	\$ _____			Boone \$ _____	\$ _____
Campbell	\$ _____	\$ _____			Campbell \$ _____	\$ _____
Kenton	\$ _____	\$ _____			Kenton \$ _____	\$ _____

Aging/MH/MR Reimbursement Request:

Boone: \$ _____ Campbell: \$ _____ Kenton: \$ _____

Signed: _____ Date: _____
Prepared By: _____

.....
Payment Amount: _____
Approved By: _____ Date: _____

NARRATIVE REPORT

Please provide a short quarterly narrative report, relating the program's progress, innovation, and problems. Also, relate any areas where gaps in service have been noted. Please identify which county you are referring to.

PROGRAM ADMINISTRATION:

CLIENT RELATED:

OTHER:

All information reported in this monthly project applies to the service and/ or programs supported by an Aging/MH/MR contract with Kenton County Fiscal Court and /or Boone County Fiscal Court and /or Campbell County Fiscal Court.

I affirm that all information contained in this report is complete and accurate to the best of my knowledge.

Signature

Date

Boone County MH/MR/AG Funding Monthly Program Report Instructions

Unduplicated Clients:

1. Number of **planned clients** who will receive service paid from Tax funds based on your application
2. Number of **planned clients** who will receive service paid from non-county Tax funds based on your application
3. Add lines 1 and 2
4. Number of **clients** for **current month** who received service paid from Tax funds
5. Number of **clients** for **current month** who received service paid from non-county Tax funds
6. Number of **clients year-to-date** who received service paid from the Tax funds
7. Number of **clients year-to-date** who received service paid from non-county Tax funds
8. Add lines 6 and 7
9. Add numbers in column 3
10. Add numbers column 8

Unit of Service

11. Number of **planned units** that will be paid from Tax funds based on your application
12. Number of **planned units** that will be paid from non-county Tax funds based on your application
13. Add lines 11 and 12
14. Number of **units of service** for current month paid from Tax funds
15. Number of **units of service** for current month paid from non-county Tax funds
16. Number of **units of service year-to-date** paid from Tax funds
17. Number of **units of service year-to-date** paid from non-county Tax funds
18. Add lines 16 and 17
19. Add numbers in column 13
20. Add numbers in column 18

Financial Information

21. Boone Co.'s allocation for Fiscal Year
22. Current month's request (#14 x #27)
23. Total amount of expenditures from **prior** months
24. Add #s 22 and 23 then subtract from 21
25. Amount of reimbursement **previously** received from Boone Co.
26. List **other funding sources** received for providing this service
27. **Boone Co.'s unit cost** based on your application
28. Reimbursement request for current month (same as #22)
29. Sign, date, and mail original Report

NOTE:

- Monthly Program Report must be typed, signed, and an original
- Submit Narrative Report quarterly