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

	Program 1	**Program 2**
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.