

**SCHEDULE OF SUB VENDORS
FISCAL YEAR _____**

PRIMARY VENDOR: _____
 COMPLETED BY: _____
 PHONE: _____

CHIEF EXECUTIVE OFFICER'S SIGNATURE Date _____
 I certify, to the best of my knowledge, that the information submitted is true and correct.

A	B	C	D	E	F	G	H	I	J	K	L
Count	DHMH Award Number	Cost Reimb. Contract - Yes or No *	Amount of Contract	If Column C is Yes and Column D is greater than \$100,000 You must Complete Columns E & F		CRF - Yes or No	Sub-Vendor's Name	Address	Federal I. D. Number	Phone Number	Purpose of Contract **
				Date of Last Audit	Period Covered In Audit						
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* A cost reimbursement contract has a line item budget and requires a Form 440 to be submitted.
 ** Purpose of Contract - e.g., to provide family planning services; to provide tobacco cessation seminars