ATTACHMENT 10

Cost Proposal Forms 10 and 10a

10. Cost Proposal Form – Albany Region

Organization Name: _____

Contact Person: _____

IFB#: 17817

Contract Period: October 1, 2018- September 30, 2023

Title/Year	Nurse Reviewer - Complaint Intake & Triage	Nurse Reviewer - Quality Assurance
Year 1 (Hrly rate)		
Year 2 (Hrly rate)		
Year 3 (Hrly rate)		
Year 4 (Hrly rate)		
Year 5 (Hrly rate)		

_____ Signature of Bidder's Authorized Representative	_____ / _____ / _____ Date
_____ Title of Authorized Representative	_____ Phone Number

Attachment 10a

10a. Cost Proposal Form- Metropolitan Area Region

Organization Name: _____

Contact Person: _____

IFB#: 17817

Contract Period: October 1, 2018- September 30, 2023

Title/Year	Social Worker	Dietician
Year 1 (Hrly rate)		
Year 2 (Hrly rate)		
Year 3 (Hrly rate)		
Year 4 (Hrly rate)		
Year 5 (Hrly rate)		

_____ Signature of Bidder's Authorized Representative	_____ / _____ / _____ Date
Title of Authorized Representative	_____ Phone Number