### SCHEDULE B

### COMPENSATION

1. **Estimated Maximum Compensation.** CARE shall pay Service Provider only for actual work performed. The following is an estimate of the maximum compensation for work performed under this Agreement:

[Specify total sum or breakdown of partial payments, etc. If there is a price listing or a breakdown of costs per specific service(s) provided, indicate here or refer to it in an attachment. **Service Providers cannot be paid on a semi-monthly or bi-weekly basis.**]

1. **Estimated Maximum Expenses.** CARE shall reimburse Service Provider only for actual reasonable expenses incurred by Service Provider without markup.The following is an estimate of the maximum reimbursable expenses:

[Insert total sum of reimbursable expenses. For example, nothing. Or total sum of transportation between such and such place, per diem allowance for lunch or dinner, hotels, copies, training materials, faxes, phone calls etc.]

No reimbursable expense in excess of five hundred dollars ($500.00) shall be incurred without CARE's prior written approval. If Service Provider travel reimbursement shall be made under this Agreement, then Service Provider shall follow CARE's travel policies and be subject to CARE per diem rates.

A fully completed CARE Travel and Expense Report (TER) is required for all travel expense reimbursements permitted under this Agreement. Service Provider must **submit original invoices and original receipts with the TER for each expense in excess of twenty-five dollars ($25.00).** The TER shall be approved and signed by CARE and submitted to the CARE Accounts Payable department. The above noted Contact/Purchase Order Number must be clearly indicated on the properly completed TER.

1. **Manner of Payment.** Service Provider's compensation and reimbursable expenses shall be paid:

Unless the Parties otherwise agree in writing, CARE shall pay Service Provider **net thirty (30) days** after receipt of proper approved invoice and/or receipt of completed and approved TER. Note that all TER s must be submitted with original invoices/receipts for each expense in excess of $25.00**.**

1. **Good-Faith Estimate of Total Payments.** The following is a good-faith estimate of the maximum payments to be made by CARE under this Agreement:

Estimated Maximum Compensation (Section 1 above): $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated Maximum Reimbursable Expenses (Section 2 above) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Estimated Maximum Sum of Contract/Purchase Order $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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