



FY2011
Public Health Emergency Response
CDC PHER Funding - Redirection

Legal Name of Applicant Agency:
Mailing Address:

Collin County

Street / PO Box: 4300 Community Avenue
City McKinney
Zip 75071

Payee Name:

Collin County

Payee Mailing Address:

Street / PO Box: 4300 Community Avenue
City McKinney
Zip 75071

State of Texas Comptroller Vendor ID No (14 digit):

Type of Entity (Choose one)

- City
- County
- Other Political Subdivision

Project Period

Start 10/1/2010
End 7/31/2011

Counties Served

- County 1 Collin County
- County 2
- County 3
- County 4
- County 5
- County 6
- County 7

Amount of Funding Requested:

ASSURANCES

The facts affirmed by me in this application are truthful. I understand that the truthfulness of the facts affirmed

Signature of Authorized Representative

Typed Name of Authorized Representative

Keith Self

Title of Authorized Representative

President

Date of Submission

10/19/10

Authorized Representative Telephone Number

(972) 548-4631

Authorized Representative E-mail Address

Fax	972-548-5574
E-mail	kstone@co.collin.tx.us
(Mailing Address):	
Street	4300 Community Avenue
City	McKinney
Zip	75071
County	Collin

First Name	Eileen
Last Name	Prentice
Title	Bioterrorism Coordinator
Phone	972-548-4384
Fax	972-548-4747
E-mail	eprentice@co.collin.tx.us
(Mailing Address):	
Street	4300 Community Avenue
City	McKinney
Zip	75071
County	Collin

First Name	Laurie
Last Name	Vining
Title	Accountant I
Phone	972-548-4796
Fax	
E-mail	lvining@co.collin.tx.us
(Mailing Address):	
Street	2300 Bloomdale Road, Ste 3100
City	McKinney
Zip	75071
County	Collin

First Name	Lawana
Last Name	Downs
Title	Bioterrorism Administrative Assistant
Phone	972-548-4383
Fax	972-548-4747
E-mail	ldowns@co.collin.tx.us
(Mailing Address):	
Street	4300 Community Avenue
City	McKinney
Zip	75071
County	Collin

First Name	Keith
Last Name	Self
Title	County Judge
Phone	972-548-4623
Fax	
E-mail	keith.self@collincountytx.gov
(Mailing Address):	
Street	2300 Bloomdale, #4192
City	McKinney
Zip	75071
County	Collin

First Name	
Last Name	
Title	
Phone	
Fax	

FORM E: BUDGET SUMMARY

Applicant Name:

Collin County

Cost Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
Percentage of Funding	100%	100%	0%	0%	0%	0%
A. Personnel	\$ 89,500.00	\$ 89,500.00				
B. Fringe Benefits	\$ 6,847.00	\$ 6,847.00				
C. Travel	\$ 1,250.00	\$ 1,250.00				
D. Equipment	\$ -	\$ -				
E. Supplies	\$ -	\$ -				
F. Contractual	\$ 633,600.00	\$ 633,600.00				
G. Other	\$ 23,100.00	\$ 23,100.00				
H. Total Direct Costs	\$ 754,297.00	\$ 754,297.00	\$ -	\$ -	\$ -	\$ -
I. Indirect Costs	\$ -	\$ -				
J. Total (Sum of H and I)	\$ 754,297.00	\$ 754,297.00	\$ -	\$ -	\$ -	\$ -
K. Program Income - Projected Earnings						

*Letters of good standing that validate the respondent's programmatic, administrative, and financial capacity must be placed after this form if respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution of higher learning, letters of good standing are not required. DO NOT include funding from other state agencies in column 4 or Federal sources in column 3 that is not related to activities being funded by this DSHS project.

FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent:

Collin County

PERSONNEL	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Functional Title + Code E = Existing or P = Proposed							
Emergency Operations Center Staff (E)	N	Use of current Collin County staff, as needed, to provide EOC staffing. Cost to cover wages over the standard 40 hours per week.	10	NA	\$60,000.00	0	\$60,000
Law Enforcement (E)	N	Use of current Collin County law enforcement officers, as needed, to provide security. Cost to cover wages over the standard 40 hours per week.	5	Peace Officer	\$50,000.00	0	\$25,000
Temporary Workers (P)	Y	Temporary workers for clinic support	3	NA	\$1,000.00	2	\$4,500
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							\$0
						SalaryWage Total	\$89,500

FRINGE BENEFITS

Itemize the elements of fringe benefits in the space below:

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765)

	Fringe Benefit Rate %	7.65%
		Fringe Benefits Total
		Revised: 7/6/2019 \$0,947

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Collin County

Conference / Workshop Travel Costs																	
Description of Conference/Workshop	Justification	Location City/State	Number of:		Travel Costs												
			Days/Employees														
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Mileage																	
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Meals																	
Lodging																	
Other Costs																	
Total	\$0																
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0												

Total for Conference / Workshop Travel

\$0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Mileage for travel to outreach clinics and various local and regional meetings	1500	\$0.500	\$750	\$500	\$1,250
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					\$0

Total for Other / Local Travel \$1,250

Other / Local Travel Costs: \$1,250

Conference / Workshop Travel Costs: \$0

Total Travel Costs: \$1,250

Indicate Policy Used:

Respondent's Travel Policy

State of Texas Travel Policy

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: Collin County

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates \$100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e. hourly rate, unit rate, lump sum amount)	TOTAL
To be named	Vaccination Administration	Provide vaccinations - fee for service at Medicare rate	Unit	33000	\$19.20	\$633,600
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL: \$633,600

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent:

Collin County

Description of Item <small>[If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]</small>	Purpose & Justification	Total Cost
Building Usage Fee	Fees for building/custodial use for potential clinics	\$3,500
EMS Support	Monitor life safety during clinics (80 hours at \$150/hour)	\$12,000
Medical Waste Disposal	Medical waste (sharps, biohazard, etc.) disposal (100 units at \$24/unit)	\$2,400
Security Support	Physical security by law enforcement during clinics (80 hours at \$40/hour)	\$3,200
Wireless Cards	Enable mobile access for clinic data entry (\$40/month)	\$2,000
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$23,100

FORM I - 7 Indirect Costs

Legal Name of Respondent:

Collin County

Total amount of indirect costs allocable to the project:

Amount:

Indirect costs are based on (mark the statement that is applicable):

The respondent's most recent indirect cost rate approved by a federal cognizant agency or state single audit coordinating agency. Expired rate agreements are not acceptable. Attach a copy of the rate agreement to this form (Form I - 7 Indirect)

RATE:
BASE:

Applies only to governmental entities. The respondent's current central service cost rate or indirect cost rate based on a rate proposal prepared in accordance with OMB Circular A-87. Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.

RATE:
TYPE:
BASE:

Note: Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date. The CFPM is available on the following internet web link: <http://www.dshs.state.tx.us/contracts/>

GO TO PAGE 2 (below)

Page 2, FORM I - 7 Indirect Costs

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**



FY2011
Public Health Emergency Response
CDC PHER Funding - Redirection

Legal Name of Applicant Agency:

Collin County

Mailing Address:

Street / PO Box: 4300 Community Avenue

City McKinney

Zip 75071

Payee Name:

Collin County

Payee Mailing Address:

Street / PO Box: 4300 Community Avenue

City McKinney

Zip 75071

State of Texas Comptroller Vendor ID No (14 digit):

Type of Entity (Choose one)

City

County

Other Political Subdivision

Project Period

Start 10/1/2010

End 7/31/2011

Counties Served

County 1 Collin County

County 2

County 3

County 4

County 5

County 6

County 7

Amount of Funding Requested:

ASSURANCES

The facts affirmed by me in this application are truthful. I understand that the truthfulness of the facts affirmed

Signature of Authorized Representative

Typed Name of Authorized Representative

Title of Authorized Representative

Date of Submission

Authorized Representative Telephone Number

Authorized Representative E-mail Address

Fax	972-548-5574
E-mail	kstone@co.collin.tx.us
(Mailing Address):	
Street	4300 Community Avenue
City	McKinney
Zip	75071
County	Collin

First Name	Eileen
Last Name	Prentice
Title	Bioterrorism Coordinator
Phone	972-548-4384
Fax	972-548-4747
E-mail	eprentice@co.collin.tx.us
(Mailing Address):	
Street	4300 Community Avenue
City	McKinney
Zip	75071
County	Collin

First Name	Laurie
Last Name	Vining
Title	Accountant I
Phone	972-548-4796
Fax	
E-mail	lvining@co.collin.tx.us
(Mailing Address):	
Street	2300 Bloomdale Road, Ste 3100
City	McKinney
Zip	75071
County	Collin

First Name	Lawana
Last Name	Downs
Title	Bioterrorism Administrative Assistant
Phone	972-548-4383
Fax	972-548-4747
E-mail	l downs@co.collin.tx.us
(Mailing Address):	
Street	4300 Community Avenue
City	McKinney
Zip	75071
County	Collin

First Name	Keith
Last Name	Self
Title	County Judge
Phone	972-548-4623
Fax	
E-mail	keith.self@collincountytx.gov
(Mailing Address):	
Street	2300 Bloomdale, #4192
City	McKinney
Zip	75071
County	Collin

First Name	
Last Name	
Title	
Phone	
Fax	

FORM E: BUDGET SUMMARY

Applicant Name:

Collin County

Cost Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
<i>Percentage of Funding</i>	100%	100%	0%	0%	0%	0%
A. Personnel	\$ -	\$ -				
B. Fringe Benefits	\$ -	\$ -				
C. Travel	\$ -	\$ -				
D. Equipment	\$ -	\$ -				
E. Supplies	\$ -	\$ -				
F. Contractual	\$ 75,000.00	\$ 75,000.00				
G. Other	\$ -	\$ -				
H. Total Direct Costs	\$ 75,000.00	\$ 75,000.00	\$ -	\$ -	\$ -	\$ -
I. Indirect Costs	\$ -	\$ -				
J. Total (Sum of H and I)	\$ 75,000.00	\$ 75,000.00	\$ -	\$ -	\$ -	\$ -
K. Program Income - Projected Earnings						

*Letters of good standing that validate the respondent's programmatic, administrative, and financial capacity must be placed after this form if respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution of higher learning, letters of good standing are not required. DO NOT include funding from other state agencies in column 4 or Federal sources in column 3 that is not related to activities being funded by this DSHS project.

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Collin County

Conference / Workshop Travel Costs																	
Description of Conference/Workshop	Justification	Location City/State	Number of:		Travel Costs												
			Days	Employees													
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Meals																	
Lodging																	
Other Costs																	
Total	\$0																
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0												

Total for Conference / Workshop Travel \$0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					\$0

Total for Other / Local Travel

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

Total Travel Costs:

Indicate Policy Used:

Respondent's Travel Policy

State of Texas Travel Policy

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: Collin County

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates \$100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e. hourly rate, unit rate, lump sum amount)	TOTAL
TALHO	Implement automated syndromic surveillance system with local hospitals	Ensures real time, automated data to assist with decision making during public health emergencies	Lump Sum	1	\$75,000.00	\$75,000
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL: \$75,000

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent:

Collin County

Description of Item <small>[If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]</small>	Purpose & Justification	Total Cost
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$0

FORM I - 7 Indirect Costs

Legal Name of Respondent:

Collin County

Total amount of indirect costs allocable to the project:

Amount:

Indirect costs are based on (mark the statement that is applicable):

_____ The respondent's most recent indirect cost rate approved by a federal cognizant agency or state single audit coordinating agency. Expired rate agreements are not acceptable. Attach a copy of the rate agreement to this form (Form I - 7 Indirect)

RATE:
BASE:

_____ ***Applies only to governmental entities.*** The respondent's current central service cost rate or indirect cost rate based on a rate proposal prepared in accordance with OMB Circular A-87. Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.

RATE:
TYPE:
BASE:

_____ **Note:** Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

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GO TO PAGE 2 (below)

Page 2, FORM I - 7 Indirect Costs

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

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Type of Entity (Choose one)
City
County
Other Political Subdivision

Project Period
Start 10/1/2010
End 7/31/2011

Counties Served
County 1 Collin County
County 2 _____
County 3 _____
County 4 _____
County 5 _____
County 6 _____
County 7 _____

Amount of Funding Requested: _____

ASSURANCES
The facts affirmed by me in this application are truthful. I understand that the truthfulness of the facts affirmed

Signature of Authorized Representative _____
Typed Name of Authorized Representative _____
Title of Authorized Representative _____
Date of Submission _____
Authorized Representative Telephone Number _____
Authorized Representative E-mail Address _____

Fax	972-548-5514
E-mail	kstone@co.collin.tx.us
(Mailing Address):	
Street	4300 Community Avenue
City	McKinney
Zip	75071
County	Collin

First Name	Eileen
Last Name	Prentice
Title	Bioterrorism Coordinator
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Fax	972-548-4747
E-mail	eprentice@co.collin.tx.us
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Zip	75071
County	Collin

First Name	
Last Name	
Title	
Phone	
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FORM E: BUDGET SUMMARY

Applicant Name:

Collin County

Cost Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
<i>Percentage of Funding</i>	100%	100%	0%	0%	0%	0%
A. Personnel	\$ 66,600.00	\$ 66,600.00				
B. Fringe Benefits	\$ 5,095.00	\$ 5,095.00				
C. Travel	\$ 2,400.00	\$ 2,400.00				
D. Equipment	\$ 6,000.00	\$ 6,000.00				
E. Supplies	\$ 63,550.00	\$ 63,550.00				
F. Contractual	\$ 33,363.00	\$ 33,363.00				
G. Other	\$ 116,595.00	\$ 116,595.00				
H. Total Direct Costs	\$ 293,603.00	\$ 293,603.00	\$ -	\$ -	\$ -	\$ -
I. Indirect Costs	\$ -	\$ -				
J. Total (Sum of H and I)	\$ 293,603.00	\$ 293,603.00	\$ -	\$ -	\$ -	\$ -
K. Program Income - Projected Earnings						

*Letters of good standing that validate the respondent's programmatic, administrative, and financial capacity must be placed after this form if respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution of higher learning, letters of good standing are not required. DO NOT include funding from other state agencies in column 4 or Federal sources in column 3 that is not related to activities being funded by this DSHS project.

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Collin County

Conference / Workshop Travel Costs		Justification	Location City/State	Number of: Days/Employees	Travel Costs	
Description of Conference/Workshop						
					Mileage	
					Airfare	
					Meals	
					Lodging	
					Other Costs	
					Total	\$0
					Mileage	
					Airfare	
					Meals	
					Lodging	
					Other Costs	
					Total	\$0
					Mileage	
					Airfare	
					Meals	
					Lodging	
					Other Costs	
					Total	\$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS						\$0

Total for Conference / Workshop Travel

\$0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Out of office meetings, seminars, exercises, training, including day travel within DFW metroplex.	1500	\$0.500	\$750	\$150	\$900
Short seminars, conferences, meetings within state of Texas.	1000	\$0.500	\$500	\$1,000	\$1,500
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					\$0

Total for Other / Local Travel \$2,400

Other / Local Travel Costs: \$2,400

Conference / Workshop Travel Costs: \$0

Total Travel Costs: \$2,400

Indicate Policy Used:

Respondent's Travel Policy

State of Texas Travel Policy

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent:

Collin County

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
Yaesu FT8800R Amateur Radio Base Station, Accessories and Installation for EOC	Redundant communication method between clinic and command staff	1	\$2,000	\$2,000
800 Trunking Radio Base Station, Accessories and Installation for EOC	Redundant communication method between first responders and command staff	1	\$4,000	\$4,000
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS				\$0

Total Amount Requested for Equipment:

\$6,000

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent:

Collin County

Itemize and describe each supply item and provide an estimated quantity and cost (i.e. #of boxes & cost/box) if applicable. Provide a justification for each supply item. Costs may be categorized by each general type (i.e., office, computer, medical, educational, etc.) See attached example for definition of supplies and detailed instructions to complete this form.

Description of Item <small>[If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]</small>	Purpose & Justification	Total Cost
Adobe Creative Suite	Software for design of brochures, flyers, and other educational materials	\$750
Directional Supplies for Clinic	Increase client throughput through use of additional interior and exterior signage, serpentine lines, etc.	\$22,000
EZ Up Speed Shelter II, Sidewalls, and Weight Bags	Field shelter for clinic registration/data entry (15 at \$800)	\$12,000
Handheld Amateur Radio and Accessories	Redundant communication method for primary response staff (4 at \$450)	\$1,800
Medical Supplies (bandaids, alcohol prep pads, etc.)	Medical supplies for pandemic response	\$6,000
Office Supplies (clipboards, paper, etc.)	Office supplies for pandemic response	\$6,000
Personal Protective Equipment (N-95 masks, gloves, etc.)	PPE for pandemic response	\$10,000
Portable Coolers	Portable coolers of various sizes for transportation and storage of vaccine	\$5,000
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Supplies:

\$63,550

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: Collin County

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates \$100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e. hourly rate, unit rate, lump sum amount)	TOTAL
TEEX	Develop and conduct a pandemic influenza tabletop exercise	Exercise to test pandemic preparedness and planning based on lessons learned during H1N1	Lump Sum	1	\$33,363.00	\$33,363
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL: \$33,363

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent:

Collin County

Description of Item <small>[If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]</small>	Purpose & Justification	Total Cost
ATT Wireless Service	Cell phone per County standards (2 at \$200)	\$400
ATT Wireless Phone	Phone/data service (2 users, \$65/month, 9 months)	\$1,170
Fees for FCC Club License	Club/vanity license for ease of contacting EOC	\$25
Outreach and Advertising	Outreach, education, and advertising materials and associated costs	\$100,000
Printing and Communication Materials	Mass printing fee for pandemic flu brochures & clinic signage	\$15,000
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$116,595

FORM I - 7 Indirect Costs

Legal Name of Respondent:

Collin County

Total amount of indirect costs allocable to the project:

Amount:

Indirect costs are based on (mark the statement that is applicable):

_____ The respondent's most recent indirect cost rate approved by a federal cognizant agency or state single audit coordinating agency. Expired rate agreements are not acceptable. Attach a copy of the rate agreement to this form (Form I - 7 Indirect)

RATE:
BASE:

_____ ***Applies only to governmental entities.*** The respondent's current central service cost rate or indirect cost rate based on a rate proposal prepared in accordance with OMB Circular A-87. Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.

RATE:
TYPE:
BASE:

_____ **Note:** Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

_____ A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date. The CFPM is available on the following internet web link: <http://www.dshs.state.tx.us/contracts/>

GO TO PAGE 2 (below)

Page 2, FORM I - 7 Indirect Costs

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**