2011-037476-001

Categorical Budget:

PERSONNEL	$70,236.00
FRINGE BENEFITS	$31,641.00
TRAVEL	$0.00
EQUIPMENT	$1,085.00
SUPPLIES	$2,187.00
CONTRACTUAL	$15,953.00
OTHER	$0.00
TOTAL DIRECT CHARGES	$121,102.00
INDIRECT CHARGES	$0.00
TOTAL	$121,102.00
DSHS SHARE	$121,102.00
CONTRACTOR SHARE	$0.00
OTHER MATCH	$0.00

Total reimbursements will not exceed $121,102.00

Financial status reports are due: 05/02/2011, 08/01/2011, 10/31/2011, 02/29/2012

Equipment List Attached.

FORM E: BUDGET SUMMARY

Applicant Name: Collin County Health Care Services

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%	18%	0%	29%	56%	0%
A. Personnel	$ 449,755.00	$ 70,236.00		$ 126,525.00	$ 281,319.00	
B. Fringe Benefits	$ 140,324.00	$ 31,641.00		$ 40,264.00	$ 86,498.00	
C. Travel	$ 2,266.00	$ -		$ 2,266.00		
D. Equipment	$ 1,085.00	$ 1,085.00				
E. Supplies	$ 4,205.00	$ 2,187.00		$ 2,018.00		
F. Contractual	$ 37,951.00	$ 15,953.00		$ 21,998.00		
G. Other	$ 526.00	$ -		$ 526.00		
H. Total Direct Costs	$ 657,889.00	$ 121,102.00	$ -	$ 193,597.00	$ 367,817.00	$ -
I. Indirect Costs		$ -				
J. Total (Sum of H and I)	$ 657,889.00	$ 121,102.00	$ -	$ 193,597.00	$ 367,817.00	$ -
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 funding by this DSHS project.

FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

PERSONNEL Functional Title + Code E = Existing or P = Proposed	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
							$0
Public Health Nurse(E)	N	Provides direct TB services	1	License	$3,528.00	12	$42,336
							$0
Contact Investigator (E) P	Y	Medical Assistant	1	Certification	$2,325.00	12	$27,900
							$0
							$0
				NA	$0.00	0	$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$70,236

FRINGE BENEFITS Itemize the elements of fringe benefits in the space below:

FICA/Medicare: 7.65%; Employee Insurance: $9.000.00 per year per employee; long-term disability: .25%; short-term disability: $1.91 per month per employee; retirement: 13.5%; Supplemental Death Benefit: .30%; Unemployment Insurance: .50%.

Fringe Benefit Rate %	45.05%
Fringe Benefits Total	$31,641

Revised: 7/6/2009

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
N/A	N/A	N/A		Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				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

Revised: 7/6/2009

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	$0.000	$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 $0

Other / Local Travel Costs: $0 Conference / Workshop Travel Costs: $0 **Total Travel Costs: $0**

Indicate Policy Used: Respondent's Travel Policy X State of Texas Travel Policy

Revised: 7/6/2009

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent: Collin County Health Care Services

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
Personal Computer (include monitor, keyboard, mouse, CDRW, MS Office Professional (Word, Excel, Access, Outlook & PowerPoint), and	Computer for proposed Medical Assistant	1	$1,085	$1,085
				$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: $1,085

Revised: 7/6/2009

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

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 (e.g., office, computer, medical, educational, etc.) See attached example for definition of supplies and detailed instructions to complete this form.

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost
Phone	Desk phone for new proposed health care analyst/contact investigator (Federal Funding)	$438
Medical Supplies	Medical supplies used in TB clinic (10 boxes of blood collection sets @ $54.42 = 544.20; paper cups 5 boxes @ 3.35/bx = 16.75; Hand Sanitizer 12 btls @ 6.46 ea. = 77.52; Vionex antimicrobial liq. Soap 2 @ 49.50 ea. = 99.00; Masks 42 boxes @ 24.09/bx = $1,011.78	$1,749
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$2,187**

Revised: 7/6/2009

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

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
Envision	CT Scann	Requested by Radiology on some patients for diagnosis	Monthly	2	$1,200.00	$2,400
Prima Care	Clinic services for TB patients after hours	Patients who have working schedules outside HCS normal DOT hours	Monthly (DOT afterhours and weekends)	147	$50.00	$7,350
Envision	Chest X-rays	Needed for TB Patients	Monthly	6	$867.17	$5,203
Heritage Eye Center	Eye Exams	Needed for TB Patients	Monthly	10	$100.00	$1,000
						$0
						$0
						$0
						$0
						$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						$0

Total Amount Requested for CONTRACTUAL: $15,953

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

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

Total Amount Requested for Other: $0

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

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

Total Amount Requested for Other: $0

Revised: 7/6/2009