FORM I: BUDGET SUMMARY INSTRUCTIONS

DSHS Costs Only Budgeted on Detail Category Pages

An accurate budget plan is essential to achieve the performance measures and work plan set out in the narrative portion of the RFP. Be sure to refer to the appropriate sections in the RFP for program-specific allowable and unallowable costs. **On each detail category budget form, budget only those costs that you plan to bill to DSHS.** The total amounts budgeted on each detail budget category form will be automatically posted to the respective budget category on "Form I - Budget Summary" under column # 2 "DSHS Funds Requested". The amounts budgeted on each detail budget MATCH category form will be automatically posted to the respective budget category on "Form I - Budget Summary" under column # 5 "Local Funding (Match)". See individual "Detailed Budget Category Forms" for definitions of the cost that are to be budgeted in each category. Enter amount as whole dollars; round up.

Column 1: The total amount of funds budgeted from all funding sources for the DSHS project. The total of all funding sources (Columns 2 - 6) for each budget category will be automatically totaled. **Do not enter amounts in Column (1) except for the amount of Program Income.**

Columns 2 - 6: Enter the amount of funding to be provided by each funding source for each "Cost Category" in columns 3 - 6.

Column 2: DSHS funds requested. (automatically posted from each detail budget category form)
Column 3 : Federal funds awarded directly to respondent to be used on the DSHS project.
Column 4: Funds awarded to respondent from other state agencies to be used on the DSHS project.
Column 5: Funds provided by local governments (city, county, hospital districts, etc) (MATCH)
Column 6: Funds from other sources. (respondents unrestricted funds including private foundations, donations, fundraising, etc)

Program Income - Projected Earnings (line K): Enter in Column 1 the total estimated the amount of program income that is expected to be generated during the budget period. The amount budgeted in column 1 should be the total program income that the project will generate. The proportionate share of program income will automatically allocate to each funding source based on the percentage of funding.

DEFINITION: Program income is defined as gross income directly generated through a contract supported activity or earned as a direct result of the contract agreement during the Program Attachment period. Refer to the instructions section below for examples of program income. In summary, program income is revenue generated by virtue of the existence of the program (activities funded under the DSHS Program Attachment).

Contractor must disburse (apply towards gross Program Attachment expenses) the DSHS share of program income before requesting reimbursement.

For more information about program income, refer to the General Provisions and the DSHS's Contractor's Financial Procedures Manual available on the Internet at: http://www.dshs.state.tx.us/contracts/cfpm.shtm

Examples Of Program Income

- *Fees for services performed in connection with and during the period of contract support;*
- *Tuition and fees when the course of instruction is developed, sponsored, and supported by DSHS contract;*
- *Sale of items fabricated or developed under the contract supported activity;*
- *Payments for contract supported services received from patients or third parties, such as Medicaid, Title XX, insurance companies;*
- *Lease or rental of items fabricated or developed under the contract supported activity; and*
- *Rights or royalty payments resulting from patents or copyrights developed or acquired by the contractor.*

Check Totals: Refer to the table below the budget template table to verify that the amounts distributed ("Distribution Total") in each budget category equals the "Budget Total" for each respective category. Next, verify that the overall total of all distributions (Distribution Totals) equals the Budget Total.

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: **COLLIN COUNTY HEALTH CARE SERVICES**

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding (Match) (5)	Other Funds **(6)**
A. Personnel	$715,747	$110,897	$72,259		$24,537	$508,054
B. Fringe Benefits	$201,327	$32,160	$20,883		$6,029	$142,255
C. Travel	$2,811	$1,705	$1,106		$0	$0
D. Equipment	$0	$0	$0		$0	$0
E. Supplies	$7,102	$4,166	$2,936		$0	$0
F. Contractual	$14,602	$2,400	$12,202		$0	$0
G. Other	$6,500	$1,500	$5,000		$0	
H. Total Direct Costs	$948,089	$152,828	$114,386	$0	$30,566	$650,309
I. Indirect Costs	$0	$0	$0		$0	
J. Total (Sum of H and I)	$948,089	$152,828	$114,386	$0	$30,566	$650,309
K. Program Income - Projected Earnings	$0	$0	$0	$0	$0	$0

NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts in whole dollars for (3), (4), & (6), *if applicable*. After amounts have been entered for each funding source, verify that the "Distribution Total" below equals the respective amount under the "Total Budget" from column (1).

	Budget Catetory	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	**Personnel**	**$715,747**	**$715,747**	**Fringe Benefits**	**$201,327**	**$201,327**
	Travel	**$2,811**	**$2,811**	**Equipment**	**$0**	**$0**
	Supplies	**$7,102**	**$7,102**	**Contractual**	**$14,602**	**$14,602**
	Other	**$6,500**	**$6,500**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$948,089**	**Budget Total**	**$948,089**

*Letter(s) of good standing that validate the respondent's programmatic, administrative, and financial capability 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 education, letter(s) 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 HEALTH CARE SERVICES**

PERSONNEL Name + Functional Title 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
Chau Nguyen- Public Health Nurse-E	N	Provides direct TB services	0.63	License	$4,976.00	12	$37,619
Lindsey Thomas-Contact Investigator-E	N	Provides direct TB services	0.63	NA	$3,779.00	12	$28,569
Kayla Herrera-Outreach Worker-E	N	Provides direct TB services	0.63	NA	$3,190.00	12	$24,116
Julia Chavez-Medical Assistant-E	N	Provides direct TB services	0.63	Certification	$2,724.00	12	$20,593
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$110,897

FRINGE BENEFITS	**Itemize the elements of fringe benefits in the space below:**	
FICA/Medicare: 7.65%; Employee Insurance: $800 monthly per employee; long-term disability: .25%; short-term disability: $1.91; long-term care based on employee election; retirement: 8.5%; Supplemental Death benefit: .3%; Unemployment Insurance: .1%		
	Fringe Benefit Rate %	29.00%
	Fringe Benefits Total	$32,160

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	
DSHS Conference/Workshop/Training	TB Program Updates, Contact Investigation Training	Austin	2 days/ 2 employees	Mileage	$150
				Airfare	$400
				Meals	$150
				Lodging	$600
				Other Costs	$0
				Total	$1,300
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $1,300

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Home visits to TB patients, visits to providers office for TB education/presentations, site visits for contact investigations	750	$0.540	$405		$405
			$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 $405

Other / Local Travel Costs: $405 Conference / Workshop Travel Costs: $1,300 **Total Travel Costs:** $1,705

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 HEALTH CARE SERVICES**

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order/quote.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
None				$0
				$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: **$0**

Revised: 1/27/2012

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
Medical Supplies - All supplies used in clinic for TB patients: blood draws for T-Spot testing, masks & sanitizer for TB protocol	Medical supplies used in TB clinic such as: (15 boxes of blood collection tubes @55.00=$825; Masks 40 boxes @$25.00/bx=$1,000; hand sanitizer 12 btls @ $6.50 ea. = $78.00; butterflies for drawing blood -16 cases @$60/per case = $965	$2,868
Medical Supplies - all supplies used for TB patients for services and sanitizing. Need sharps to dispose of biohazard waste.	Antimicrobial Liq. Soap: 20 btls @$8.02 ea. = $160; Caviwipes Tub: 20 ea. @$7.09 ea.=$142.00; Diamond Grip Gloves Med. 10 bxs @$9.89 bx. = $99.00; Diamond Grip Gloves Lge-10bxs @$9.89 bx = $99; Vacutainer Needle Holder 10 bags @ $9.94 bg = $99.00; Sharps containers 3cs @ $61.20 case = $184	$783
Medical Supplies - TB supplies necessary for the administration of PPDs and blood draws.	Curity Alcohol preps 10 bxs @4:00 bx = $40.00; Coverlet strip pieces 20bxs @ 1:00 bx = $20	$60
General Office Supplies	Pens for patients to fill out forms, self stick notes, highlighters	$200
Reference Materials	TB reference books/education for providers and TB staff	$255
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$4,166**

Revised: 1/27/2012

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
Jerry Barnett	Pharmacist	Needed for TB patients' meds	Monthly	12	$200.00	$2,400
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for CONTRACTUAL: $2,400

Revised: 1/27/2012

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
Language Line	Translation service for TB patients	$1,500
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$1,500**

Revised: 1/27/2012

FORM I-1: PERSONNEL Budget Category Detail Form (Match)

Legal Name of Respondent: **COLLIN COUNTY HEALTH CARE SERVICES**

PERSONNEL Name + Functional Title 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
Rayola Leggett-Nurse E	N	Provides TB Services	0.39	License	$5,243.00	12	$24,537
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$24,537

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

FICA/Medicare: 7.65%; Employee Insurance: $800 monthly per employee; long-term disability: .25%; short-term disability: $1.91; long-term care based on employee election; retirement: 8.5%; Supplemental Death benefit: .3%; Unemployment Insurance: .1%

Fringe Benefit Rate %	24.57%
Fringe Benefits Total	$6,029