TEXAS Department of State Health Services

Department of State Health Services
FORM A: FACE PAGE

CONTRACTOR INFORMATION

1) LEGAL BUSINESS NAME: Collin County Health Care Services

2) MAILING Address Information (include mailing address, street, city, county, state and 9-digit zip code): **Check if address change** ☐

825 N. McDonald St., Suite 145, McKinney, TX 75069

3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above): **Check if address change** ☐

Collin County Auditor's Office, 2300 Bloomdale Road, Suite 3100, McKinney, TX 75071

4) DUNS Number (9-digit) required if receiving federal funds: NA

5) Federal Tax ID No. (9-digit), **State of Texas Comptroller Vendor ID Number** (14-digit) or **Social Security Number** (9-digit): 756000873

The respondent acknowledges, understands and agrees that the respondent's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.

6) TYPE OF ENTITY (check all that apply):

- ☐ City
- ☒ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith Based (Nonprofit Org)
- ☐ Individual
- ☐ Federally Qualified Health Centers
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

If incorporated, provide 10-digit charter number assigned by Secretary of State:

7) PROPOSED BUDGET PERIOD: **Start Date:** 09/01/2015 **End Date:** 08/31/2017

8) COUNTIES SERVED BY PROJECT:

Collin County

9) AMOUNT OF FUNDING REQUESTED: $78,475.00

10) PROJECTED EXPENDITURES

Does respondent's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for respondent's current fiscal year (excluding amount requested in line 9 above)? **

Yes ☐ No ☒

***Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.*

11) PROJECT CONTACT PERSON

Name: Joann Gilbride
Phone: 972-548-5503
Fax: 972-548-4441
Email: jgilbride@co.collin.tx.us

12) FINANCIAL OFFICER

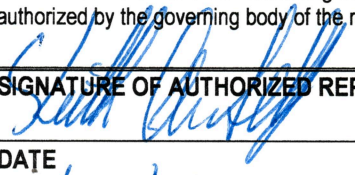
Name: JEFF MAY
Phone: 972-548-4641
Fax: 972-548-4696
Email: jgilbride@co.collin.tx.us

The facts affirmed by me in this proposal are truthful and I warrant the respondent is in compliance with the assurances and certifications contained in **APPENDIX B: DSHS Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the respondent and I (the person signing below) am authorized to represent the respondent.

13) AUTHORIZED REPRESENTATIVE **Check if change** ☐

Name: KEITH SELF
Title: County Judge
Phone: 972-548-4635
Fax: 972-548-4699
Email: Keith.self@co.collin.tx.us

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE



15) DATE

5/23/16

FORM C: CONTACT PERSON INFORMATION

Legal Business Name of Contractor Collin County Health Care Services

This form provides information about the appropriate contacts in the respondent's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Management Unit. Please provide at least one (1) Emergency Contact as noted below.

Emergency Contact:	Candy Blair	Mailing Address (incl. street, city, county, state, & zip):
Title:	Health Care Administrator	825 N. McDonald St., Suite 145
Phone:	972-548-5504	McKinney
Fax:	972-548-4441	Collin County
Email:	cblair@co.collin.tx.us	Texas 75069
Contact:	Joann Gilbride	Mailing Address (incl. street, city, county, state, & zip):
Title:	HC Coordinator	825 N. McDonald St., Suite 145
Phone:	972-548-5503	McKinney
Fax:	972-548-4441	Collin County
Email:	jgilbride@co.collin.tx.us	Texas, 75069
Contact:	Eileen Prentice	Mailing Address (incl. street, city, county, state, & zip):
Title:	Accountant, Audit Specialist	2300 Bloomdale Rd, Suite 300
Phone:	972-548-4796 Ext.	McKinney
Fax:	972-548-4751	Collin County
Email:	eprentice@co.collin.tx.us	Texas, 75071
Contact:	Janna Benson-Caponera	Mailing Address (incl. street, city, county, state, & zip):
Title:	Grant Supv—Auditor's Office	2300 Bloomdale Rd, Suite 300
Phone:	972-548-4638 Ext.	McKinney
Fax:	972-548-4751	Collin County
Email:	jcaponera@co.collin.tx.us	Texas, 75071
Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:	Ext.	
Fax:		
Email:		

FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the Contractor and the proposed project with the Department of State Health Services (DSHS), including the signature of the authorized representative. Please follow the instructions below to complete the face page form and return to the Contractor Management Unit.

1) LEGAL BUSINESS NAME - Enter the legal name of the respondent.

2) MAILING ADDRESS INFORMATION - Enter the respondent's complete physical address and mailing address, city, county, state, and 9-digit zip code.

3) PAYEE NAME AND MAILING ADDRESS - Payee – Entity involved in a contractual relationship with respondent to receive payment for services rendered by respondent and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address, including 9-digit zip code, if PAYEE is different from the respondent. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) DUNS Number – 9- digit Dun and Bradstreet Data Universal Numbering System (DUNS) number. . This number is required if receiving ANY federal funds and can be obtained at: http://fedgov.dnb.com/webform

5) FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER - Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The respondent acknowledges, understands and agrees the respondent's choice to use a social security number as its vendor identification number for the contract, may result in the social security number being made public via state open records requests.

6) TYPE OF ENTITY - Check the type of entity as defined by the Secretary of State at http://www.sos.state.tx.us/corp/businessstructure.shtml and/or the Texas State Comptroller at https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf and check all other boxes that describe the entity.

   Historically Underutilized Business: A minority or women-owned business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. (http://www.window.state.tx.us/procurement/prog/hub/)
   State Agency: an agency of the State of Texas as defined in Texas Government Code §2056.001.ii
   Institutions of higher education as defined by §61.003 of the Education Code.
   MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.
   If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

7) PROPOSED BUDGET PERIOD - Enter the budget period for this proposal. Budget period is defined in the RFP. *[To be completed by RFP developer]*

8) COUNTIES SERVED BY PROJECT - Enter the proposed counties served by the project. *[If service area is pre-determined, to be completed by RFP developer]*

9) AMOUNT OF FUNDING REQUESTED - Enter the amount of funding requested from DSHS for proposed project activities (not including possible renewals). This amount must match column (1) row K from the BUDGET SUMMARY used for cost reimbursement budgets.

10) PROJECTED EXPENDITURES - If respondent's projected federal expenditures exceed $500,000 or its projected state expenditures exceed $500,000 for respondent's current fiscal year, respondent must arrange for a financial compliance audit (Single Audit).

11) PROJECT CONTACT PERSON - Enter the name, phone, fax, and email address of the person responsible for the proposed project.

12) FINANCIAL OFFICER - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.

13) AUTHORIZED REPRESENTATIVE - Enter the name, title, phone, fax, and email address of the person authorized to represent the respondent. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE - The person authorized to represent the respondent must sign in this blank.

15) DATE - Enter the date the authorized representative signed this form.

FORM C : CONTACT PERSON INFORMATION INSTRUCTIONS

Please provide at least one (1) Emergency Contact.

General Instructions for Completing Budget Forms
DSHS Costs Only Budgeted on Detail Category Pages

(Examples and instructions for completing the Budget Category Detail Templates are in a separate Excel file located under Templates for Cost Reimbursement Budgets located at :
http://www.dshs.state.tx.us/grants/forms.shtm

* Enter the legal name of your organization in the space provided for "Legal Name of Respondent" on Form I -Budget Summary; doing so will populate the budget category detail templates with your organizations name.

* Complete each budget category detail template. Instructions for completing each budget category detail template are in a separate document. If a primary budget category detail template does not accommodate all items in your budget, use the respective supplemental budget template at the end of this workbook. The total of each supplemental category detail budget template will automatically populate to the last line of the respective primary budget category template.

* After you have completed each budget category detail form, go to Form I-Budget Summary and input other sources of funding manually (if any) in Columns 3 - 6 for each budget category.

* 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.

* Enter the total amount of "Program Income" anticipated for this program in row "K" under the "Total Budget" column (1). The total program income budgeted will be automatically allocated to each funding source based on the percentage of funding of the total budget. Information on program income is available in the DSHS Contractors Financial Procedures Manual located at the following web site: http://www.dshs.state.tx.us/contracts/

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 Sources (5)	Other Funds **(6)**
A. Personnel	$54,734	$54,734	$0	$0	$0	$0
B. Fringe Benefits	$19,317	$19,317	$0	$0	$0	$0
C. Travel	$1,162	$1,162	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$1,774	$1,774	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$1,488	$1,488	$0	$0	$0	$0
H. Total Direct Costs	$78,475	$78,475	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$78,475	$78,475	$0	$0	$0	$0
K. Program Income - Projected Earnings	$0	$0				

NOTE: The "Total Budget" amount for each Budget Category will have to be allocated (entered) manually among the funding sources. Enter amounts in whole dollars. 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**	**$54,734**	**$54,734**	**Fringe Benefits**	**$19,317**	**$19,317**
	Travel	**$1,162**	**$1,162**	**Equipment**	**$0**	**$0**
	Supplies	**$1,774**	**$1,774**	**Contractual**	**$0**	**$0**
	Other	**$1,488**	**$1,488**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$78,475**	**Budget Total**	**$78,475**

*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 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
Epidemiologist-P	Y	Coordinates epidemiology services and disease investigation	0.94	NA	$4,852.33	12	$54,734
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$54,734

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

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($875 for medical/dental/RX and $4.95 for term life per month), Long Term Disability (salary x 0.0025), Short Term Disability $1.91/month, Long Term Care $15/month, Retirement (salary x 0.08), Supplement Death Benefit (salary x 0.0026), Unemployment Insurance (salary x 0.001);

	Fringe Benefit Rate %	35.29%
	Fringe Benefits Total	$19,317

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	
DSHS Training / Conference in Austin /Epi Workshop	Training for updates; Mileage to drive to conference 470 miles@ $.575 = $270; meals perdiem $200, Hotel 3 nights at $170/night; tolls $20	Austin, TX	3 days, 1 employee	Mileage	$270
				Airfare	
				Meals	$200
				Lodging	$510
				Other Costs	$20
				Total	$1,000
				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 $1,000

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Mileage to and from hospitals, patient homes, providers' offices, for disease investigations and education	300	$0.540	$162		$162
			$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 $162

Other / Local Travel Costs: $162 Conference / Workshop Travel Costs: $1,000 **Total Travel Costs:** $1,162

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. 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
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: 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
Stastical Software (IBM/SPSS)	Needed for Analyzing disease investigation data	$800
General Office Supplies	Supplies needed for filing, creating epidemiology reports	$974
		$0
		$0
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$1,774**

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
none						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						$0

Total Amount Requested for CONTRACTUAL: $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
Printed Brochures and other Materials	Education on diseases and health habits for community stakeholders and the public	$500
Monthly Service-iPhone	Required for the cell phone--$55/month data usage plan x 12 mo	$660
Reference Materials	Related reference books for health department education on infectious diseases	$328
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$1,488**

Revised: 7/6/2009