



**Inter-Local
Application
For
Tuberculosis Prevention and
Control for FY 2017
State Funds**

<http://www.dshs.state.tx.us/idcu/disease/tb>

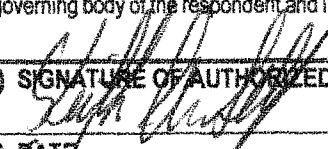
TB Services Branch

1100 W. 49th Street
P. O. Box 149347, MS 1990
Austin, Texas 78714

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**Department of State Health Services
Form A Face Page – Tuberculosis (TB) Funding**

RESPONDENT 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):	825 N McDonald St., Suite 130, McKinney, TX 75069 Check if address change <input type="checkbox"/>
3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above):	Collin County Auditor's Office, 2300 Bloomdale Road, Suite 3100, McKinney, TX 75070 Check if address change <input type="checkbox"/>
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
<small>*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.</small>	
6) TYPE OF ENTITY (check all that apply):	
<input type="checkbox"/> City <input checked="" type="checkbox"/> County <input type="checkbox"/> Other Political Subdivision <input type="checkbox"/> State Agency <input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Nonprofit Organization* <input type="checkbox"/> For Profit Organization* <input type="checkbox"/> HUB Certified <input type="checkbox"/> Community-Based Organization <input type="checkbox"/> Minority Organization <input type="checkbox"/> Faith Based (Nonprofit Org)
<input type="checkbox"/> Individual <input type="checkbox"/> Federally Qualified Health Centers <input type="checkbox"/> State Controlled Institution of Higher Learning <input type="checkbox"/> Hospital <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): _____	
<small>*If incorporated, provide 10-digit charter number assigned by Secretary of State: _____</small>	
7) PROPOSED BUDGET PERIOD:	Start Date: 09/01/2016 End Date: 08/31/2017
8) COUNTIES SERVED BY PROJECT: COLLIN	
9) AMOUNT OF FUNDING REQUESTED: \$152,828	11) PROJECT CONTACT PERSON
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 <input type="checkbox"/> No <input checked="" type="checkbox"/> <small>**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.</small>	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: jmay@co.collin.tx.us	
<small>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.</small>	
13) AUTHORIZED REPRESENTATIVE Check if change <input type="checkbox"/>	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE
Name: KEITH SELF Title: COUNTY JUDGE Phone: 972-548-4635 Fax: 972-548-4699 Email:	 15) DATE 7/25/16

FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the respondent and the proposed project with the Department of State Health Services (DSHS), including the signature of the authorized representative. It is the cover page of the proposal and is required to be completed. Signature affirms the facts contained in the respondent's response are truthful and the respondent is in compliance with the assurances and certifications contained in **APPENDIX B: DSHS Assurances and Certifications** and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below to complete the face page form and return with the respondent's proposal.

- 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.
- 8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.
- 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

Legal Business Name of Contractor:

COLLIN COUNTY HEALTH CARE SERVICES

*This form provides information about the appropriate contacts in the contractor'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**.*

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 D: ADMINISTRATIVE INFORMATION - ILA

*This form provides information regarding identification and contract history on the applicant, executive management, project management, governing board members, and/or principal officers. Respond to each request for information **or provide the required supplemental document behind this form.** If responses require multiple pages, identify the supporting pages/documentation with the applicable request.*

COLLIN COUNTY HEALTH CARE SERVICES

Legal Name of Applicant: _____

Identifying Information

The applicant shall attach the following information:

- Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the applicant.

Conflict of Interest and Contract History

The applicant shall disclose any existing or potential conflict of interest relative to the performance of the requirements of this Application for Funding. Examples of potential conflicts may include an existing business or personal relationship between the applicant, its principal, or any affiliate or subcontractor, with DSHS, the participating agencies, or any other entity or person involved in any way in any project that is the subject of this Application for Funding. Similarly, any personal or business relationship between the applicant, the principals, or any affiliate or subcontractor, with any employee of DSHS, a participating agency, or their respective suppliers, must be disclosed. Any such relationship that might be perceived or represented as a conflict shall be disclosed. Failure to disclose any such relationship may be cause for contract termination or disqualification of the proposal. If, following a review of this information, it is determined by DSHS that a conflict of interest exists, the applicant may be disqualified from further consideration for the award of a contract.

1. Does anyone in the applicant organization have an existing or potential conflict of interest relative to the performance of the requirements of this Application for Funding?

YES NO

If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)

2. Has any member of applicant's executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the application due date?

YES NO

If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation.

FORM D: ADMINISTRATIVE INFORMATION – ILA - continued

3. Has applicant had a contract with DSHS within the past 24 months?

YES NO

If YES, indicate the contract number(s):

Contract Number(s)	
Contract Number	Grant
2015-001394	TB STATE
2015-001388	TB FEDERAL
2015-046581	FOODBORNE
2016-001266	IMMUNIZATIONS
2016-001394	TB STATE
2016-001289	RLSS/LPHS
2016-003819	IDCU/SUREB

If NO, applicant must be able to demonstrate fiscal solvency. Submit a copy of the organization's most recently audited balance sheet, statement of income and expenses and accompanying financial footnotes DSHS will evaluate the documents that are submitted and may, at its sole discretion, reject the proposal on the grounds of the applicant's financial capability.

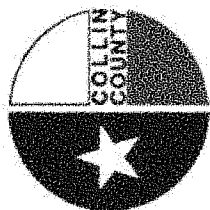
4. Is applicant or any member of applicant's executive management, project management, board members or principal officers:

- Delinquent on any state, federal or other debt;
- Affiliated with an organization which is delinquent on any state, federal or other debt; or
- In default on an agreed repayment schedule with any funding organization?

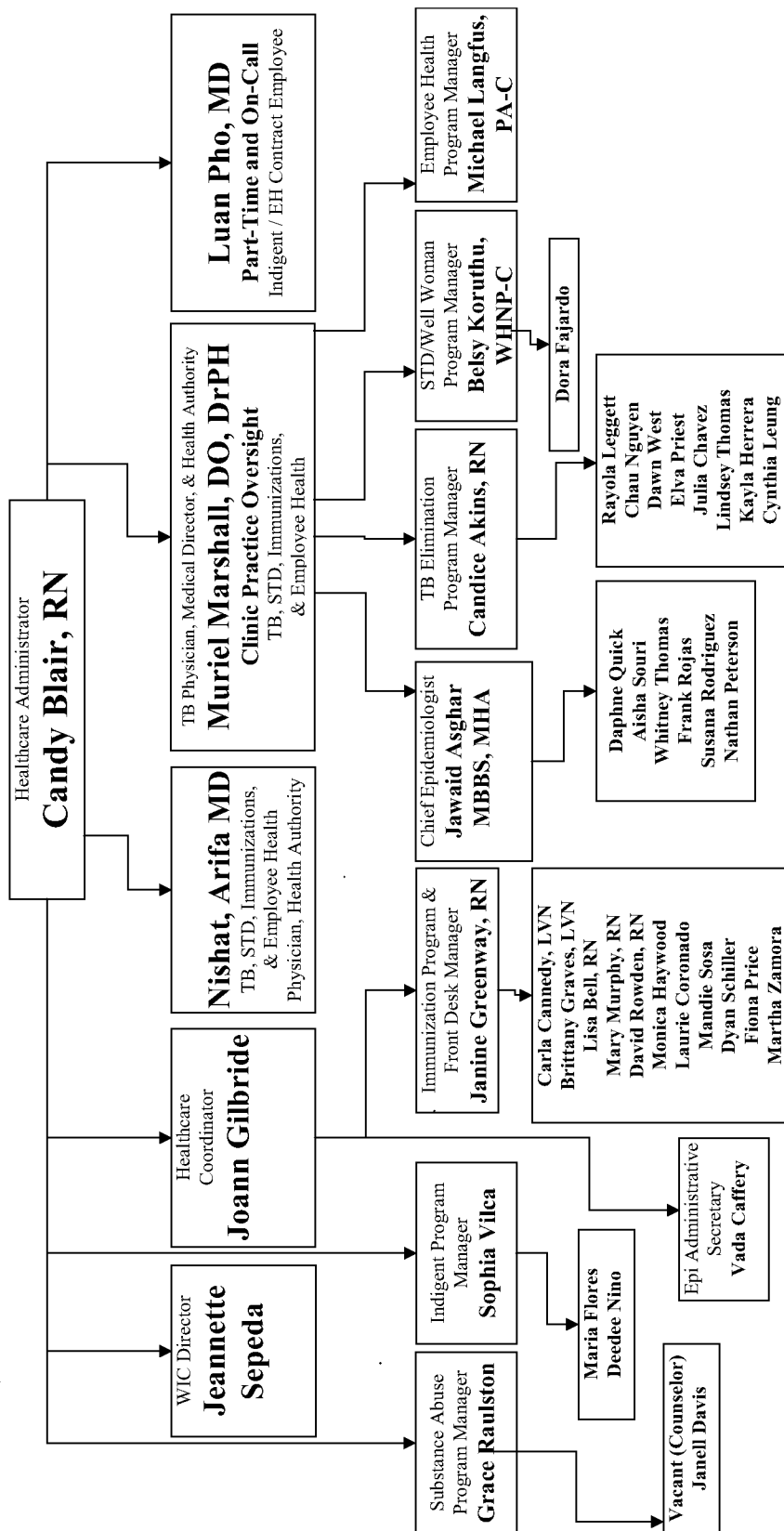
YES NO

If YES, please explain. (Attach no more than one additional page.)

FORM E: ORGANIZATION, RESOURCES AND CAPACITY
(Organizational Chart)



COLLIN COUNTY HEALTH CARE SERVICES
ORGANIZATIONAL CHART



Revised 6/13/2016

FORM F: PERFORMANCE MEASURES

In the event a contract is awarded, applicant agrees that performance measures will be used to assess, in part, the applicant's effectiveness in providing the services described.

1. Newly-reported TB cases shall have an HIV test performed (unless they are known HIV-positive, or if the patient refuses) and shall have positive or negative HIV test results reported to DSHS according to the reporting schedule provided in Section 1, B herein.

For FY17 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 82.9% is required.

If fewer than 82.9% of newly reported TB cases have a result of an HIV test reported, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

2. Cases, and suspected cases, of TB under treatment by Contractor shall be placed on timely and appropriate Directly Observed Therapy (DOT).

For FY17 reporting, data will cover all cases from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 91.6% is required.

If data indicates a compliance percentage for this Performance Measure of less than 91.6%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

3. Newly-reported suspected cases of TB disease shall be started in timely manner on the recommended initial 4-drug regimen.

For FY17 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 93.4% is required.

If fewer than 93.4% of newly-reported TB cases are started on an initial 4-drug regimen in accordance with this requirement, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

4. Newly-reported TB patients that are older than 12-years-old and that have a pleural or respiratory site of disease shall have sputum acid-fast bacilli (AFB)-culture results reported to DSHS according to the timelines for reporting initial and updated results given herein.

For FY17 reporting, data will be drawn from calendar year 2015 (1/1/2016 -12/31/2016). A compliance percentage of not less than 91.5% is required.

If data indicates a compliance percentage for this Performance Measure of less than 91.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

5. Newly-reported cases of TB with AFB positive sputum culture results will have documented conversion to sputum culture-negative within 60 days of initiation of treatment.

For FY17 reporting, data will be drawn from calendar year 2015 (1/1/2015-12/31/2015). A compliance percentage of not less than 95% is required.

If data indicates a compliance percentage for this Performance Measure of less than 95%, then DSHS may (at its sole discretion) require additional measures be taken by contractor to improve the percentage, on a timeline set by DSHS;

6. Newly diagnosed TB cases that are eligible* to complete treatment within 12 months shall complete therapy within 365 days or less.

*Exclude TB cases 1) diagnosed at death, 2) who die during therapy, 3) who are resistant to Rifampin, 4) who have meningeal disease, and/or 5) who are younger than 15 years with either miliary disease or a positive blood culture for TB.

For FY17 reporting, data will cover all cases from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 87% is required.

If data indicates a compliance percentage for this Performance Measure of less than 87%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

7. Increase the proportion of culture-confirmed TB cases with a genotyping result reported.

For FY17 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 94.2% is required.

If data indicates a compliance percentage for this Performance Measure of less than 94.2%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

8. TB cases with initial cultures positive for Mycobacterium tuberculosis complex shall be tested for drug susceptibility and have those results documented in their medical record.

For FY17 reporting, data will be drawn from calendar year 2015 (1/1/2015 -12/31/2015). A compliance percentage of not less than 97.8% is required.

If data indicates a compliance percentage for this Performance Measure of less than 97.8%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

9. Newly-reported TB patients with a positive AFB sputum-smear result shall have at least three contacts identified as part of the contact investigation that must be pursued for each case.

For FY17 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 92% is required.

If data indicates a compliance percentage for this Performance Measure of less than 92%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

10. Newly-identified contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive TB case shall be evaluated for TBI and disease.

For FY17 reporting, data will be drawn from calendar year 2015 (1/1/2015 -12/31/2015). A compliance percentage of not less than 82.5% is required.

If data indicates a compliance percentage for this Performance Measure of less than 82.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

11. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case and that are newly diagnosed with TBI shall be started on timely and appropriate treatment.

For FY17 reporting, data will be drawn from calendar year 2015 (1/1/2015 -12/31/2015). A compliance percentage of not less than 70% is required.

If data indicates a compliance percentage for this Performance Measure of less than 70%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

12. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case that are newly diagnosed with TBI and that were started on treatment shall complete treatment for TBI as described in Targeted Tuberculin Testing and Treatment of Latent TB Infection (LTBI), Morbidity and Mortality Weekly Report, Vol. 49, No. RR-6, 2000; according to timelines given, therein.

For FY17 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 50% is required.

If data indicates a compliance percentage for this Performance Measure of less than 50%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

13. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB, increase the proportion who initiate a medical evaluation within 30 days of arrival. Arrival is defined as the first notice or report; whether that is by fax, phone call, visit to the health department or EDN notification.

For FY17 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 62% is required.

If data indicates a compliance percentage for this Performance Measure of less than 62%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

14. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB, increase the proportion who initiate and complete a medical evaluation within 90 days of arrival.

For FY17 reporting data will be drawn from calendar year 2016 (1/1/2016-12/31/2016). A compliance percentage of not less than 60% is required.

If data indicates a compliance percentage for this Performance Measure of less than 60%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

15. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB and who are diagnosed with TBI during evaluation in the US, increase the proportion who start treatment.

For FY17 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 64% is required.

If data indicates a compliance percentage for this Performance Measure of less than 64%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS; and

16. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB and who are diagnosed with TB infection during evaluation in the US and started on treatment, increase the proportion who complete treatment for TB infection.

For FY17 reporting, data will be drawn from calendar year 2015 (1/1/2015 -12/31/2015). A compliance percentage of not less than 70% is required.

If data indicates a compliance percentage for this Performance Measure of less than 70%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.

Contractor shall maintain documentation used to calculate performance measures as required by General Provisions Article VIII "Records Retention" and by Texas Administrative Code Title 22, Part 9 Chapter 165, §165.1 regarding retention of medical records.

All reporting to DSHS shall be completed as described in Section I, "D. Reporting" and submitted by the deadlines given.

If Contractor fails to meet any of the performance measures, Contractor shall furnish in the Annual Progress Report, due March 15, 2016, a written narrative explaining the barriers and the plan to address those barriers. This requirement does not excuse any violation of this Contract, nor does it limit DSHS as to any options available under the contract regarding breach.

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.shtml>

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	\$0
H. Total Direct Costs	\$948,089	\$152,828	\$114,386	\$0	\$30,566	\$650,309
I. Indirect Costs	\$0	\$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 Category	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
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*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
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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:	Travel Costs		
			Days/Employees			
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

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 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**

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent:

COLLIN COUNTY HEALTH CARE SERVICES

Description of Item <small>[If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]</small>	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

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

Legal Name of Respondent:

COLLIN COUNTY HEALTH CARE SERVICES

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
Name + Functional Title E = Existing or P = Proposed							
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
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