2012-040161-001

Categorical Budget:

PERSONNEL	$71,628.00
FRINGE BENEFITS	$22,205.00
TRAVEL	$1,579.00
EQUIPMENT	$0.00
SUPPLIES	$4,598.00
CONTRACTUAL	$35,979.00
OTHER	$0.00
TOTAL DIRECT CHARGES	$135,989.00
INDIRECT CHARGES	$0.00
TOTAL	$135,989.00
DSHS SHARE	$135,989.00
CONTRACTOR SHARE	$0.00
OTHER MATCH	$0.00

Total reimbursements will not exceed $135,989.00

Financial status reports are due: 04/30/2012, 07/31/2012, 10/31/2012, 03/01/2013

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	$523,560	$71,628	$0	$142,932	$309,000	$0
B. Fringe Benefits	$188,081	$22,205	$0	$45,137	$120,739	$0
C. Travel	$2,579	$1,579	$0	$0	$1,000	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$4,598	$4,598	$0	$0	$0	$0
F. Contractual	$56,803	$35,979	$0	$20,824	$0	$0
G. Other	$0	$0	$0	$0	$0	$0
H. Total Direct Costs	$775,621	$135,989	$0	$208,893	$430,739	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$775,621	$135,989	$0	$208,893	$430,739	$0
K. Program Income - Projected Earnings	$0	$0		$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**	**$523,560**	**$523,560**	**Fringe Benefits**	**$188,081**	**$188,081**
	Travel	**$2,579**	**$2,579**	**Equipment**	**$0**	**$0**
	Supplies	**$4,598**	**$4,598**	**Contractual**	**$56,803**	**$56,803**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$775,621**	**Budget Total**	**$775,621**

*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
Rachel Shepard, RN - E	N	Provides case management services	1	License	$3,598.00	12	$43,176
Angie Allen - E	N	Provides case registrar, CI mangement & data base	1	NA	$2,371.00	12	$28,452
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$71,628

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

FICA/Medicare: 7.65%; Employee Insurance: $8,475 per year per employee; long-term disability: .367%; short-term disability: $2.25 per month per employee; retirement: 13%; Supplemental Death Benefit: .29%; Unemployment Insurance: .50%.

Fringe Benefit Rate %	31.00%
Fringe Benefits Total	$22,205

Revised: 7/6/2009

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
Contact Investigation Training	Training for Medical Assistant who is backup for Contact Investigator (Location TBA possibly Austin - 2 nights @ 110; meals 3 days (35 per day); 500 @.555 per mile; other costs-Tolls and/or tips	TBA	1	Mileage	$278
				Airfare	$0
				Meals	$105
				Lodging	$220
				Other Costs	$20
				Total	$623
Twices training for Medical Assistant	Training for Medical Assistant for Case Registrar (Location TBA possibly Austin - 2 nights @ 110; meals 3 days (35 per day); 500 @.555 per mile; other costs-Tolls and/or tips	TBA	1	Mileage	$278
				Airfare	$0
				Meals	$105
				Lodging	$220
				Other Costs	$20
				Total	$623
				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 $1,246

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
DOT for TB patients	600	$0.555	$333		$333
			$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 $333

Revised: 7/6/2009

Other / Local Travel Costs:	$333	Conference / Workshop Travel Costs:	$1,246	**Total Travel Costs:**	**$1,579**

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
				$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
Medical Supplies	Medical supplies used in TB clinic (10 boxes of blood collection tubes @55.00 = $550.00; Masks 40 boxes @ 24.25/bx. = 970.00; Hand Sanitizer 12 btls @ 6.50 ea. = 78.00; Butterflies for drawing blood 20 cases @ $60 per case = $1,200	$2,798
Office Supplies	Shipping boxes for sputum for overnight testing $45 per case (10 per case) x 40 cases =$1,800	$1,800
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$4,598**

Revised: 7/6/2009

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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	Chest X-rays	Needed for TB patients	Monthly	12	$735.33	$8,824
Envision	CT Scans	Needed for TB patients	Monthly	6	$275.00	$1,650
Opthamalogist	Vision Check	Needed for TB patients	Monthly	4	$100.00	$400
Prima Care	DOT services for TB patients after hours	Needed for TB patients	Monthly	12	$800.00	$9,600
Oxford Diagnostic Labs.	T-spot Testing	Needed for TB patients	Monthly	12	$1,292.08	$15,505
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for CONTRACTUAL: $35,979

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
		$0
		$0
		$0
		$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: **$0**

Revised: 7/6/2009

FORM I - 7 Indirect Costs

Legal Name of Respondent: Collin County Health Care Services

Total amount of indirect costs allocable to the project: Amount: $0

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.**

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.

RATE:
TYPE:
BASE:

_____ 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:**