FY2014

PHEP Funding

Applicant Information

Legal Name of Applicant Agency/Contract #:	Collin County
Mailing Address:	
Street / PO Box:	4300 Community Ave
City:	McKinney
Zip:	75071
Payee Name:	Collin County
Payee Mailing Address:	
Street / PO Box:	4300 Community Ave
City:	McKinney
Zip:	75071
State of Texas Comptroller Vendor ID # (9 digit + 3 digit mail code)**:**	
DUNS # (9 digits required for subrecipient contractors)**:**	074873449

Type of Entity (Choose one)

City:	☐	Click on appropriate box
County:	☑	
Other Political Subdivision:	☐	

Project Period

Start Date:	9/1/2013
End Date:	8/31/2014

Counties Served

County(ies) Served:	Collin County
Amount of Funding Requested:	$ 538,709.00

CONTACT PERSON INFORMATION

Legal Business Name: Collin County

This form provides information about the appropriate contacts in the contractor's organization in addition to those on the FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Management Unit.

Executive Director	Keith Self			Mailing Address (street, city, county, state, & zip):
Phone:	(972) 548-4623	Ext:		
Fax:				
E-mail:	keith.self@collincountytx.gov			2300 Bloomdale, #4192, McKinney, TX 75071
Financial Rep:	Eileen Prentice			Mailing Address (street, city, county, state, & zip):
Phone:	(972) 548-4796	Ext:		
Fax:	(972) 548-4751			
E-mail:	eprentice@co.collin.tx.us			2300 Bloomdale, #3100, McKinney, TX 75071
Lead Program/Project Leader:	Jacob Bathman			Mailing Address (street, city, county, state, & zip):
Phone:	(972) 548-5535	Ext:		
Fax:	(972) 548-4747			
E-mail:	jbathman@co.collin.tx.us			2300 Bloomdale, #3100, McKinney, TX 75071
SNS Coordinator: if applicable	Ashleigh Foy			Mailing Address (street, city, county, state, & zip):
Phone:	(214) 491-6840	Ext:		
Fax:	(972) 548-4747			
E-mail:	afoy@co.collin.tx.us			4300 Community Ave, McKinney, TX 75071
Authorized Signatory	Keith Self			Mailing Address (street, city, county, state, & zip):
Phone:	(972) 548-4623	Ext:		
Fax:				
E-mail:	keith.self@collincountytx.gov			2300 Bloomdale, #4192, McKinney, TX 75071
Emergency Contact	Kelley Stone			Mailing Address (street, city, county, state, & zip):
Cell Phone:	(214) 686-6111	Ext:		
Fax:	(972) 548-4747			
E-mail:	kstone@co.collin.tx.us			4300 Community Ave, McKinney, TX 75071
CMPS System Admin:	Janna Benson-Caponera			Mailing Address (street, city, county, state, & zip):
Phone:	(972) 548-4638	Ext:		
Fax:	(972) 548-4751			
E-mail:	jbenson-caponera@co.collin.tx.us			2300 Bloomdale, #3100, McKinney, TX 75071

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**

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	$394,829	$379,282			$15,547	
B. Fringe Benefits	$118,762	$114,276			$4,486	
C. Travel	$6,802	$6,802			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$8,000	$8,000			$0	
F. Contractual	$0	$0			$0	
G. Other	$64,204	$30,349			$33,855	
H. Total Direct Costs	$592,597	$538,709	$0	$0	$53,888	$0
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$592,597	$538,709	$0	$0	$53,888	$0
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**	**$394,829**	**$394,829**	**Fringe Benefits**	**$118,762**	**$118,762**
	Travel	**$6,802**	**$6,802**	**Equipment**	**$0**	**$0**
	Supplies	**$8,000**	**$8,000**	**Contractual**	**$0**	**$0**
	Other	**$64,204**	**$64,204**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$592,597**	**Budget Total**	**$592,597**

*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**

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
Jake Bathman, PHEM Coordinator (E)	N	Coordinates PHEP grant deliverables & activities, supervises PHEP team	1	NA	$4,772.00	12	$57,264
Lacie Reitmeyer, PHEM Planner (E)	N	Performs PHEP activities including special needs, first responder safety, hospital coordination	1	NA	$4,145.00	12	$49,740
Amy Davis, Administrative Assistant, BT (E)	N	Tracks & maintains documentation for PHEP team	1	NA	$2,920.00	12	$35,040
Stephen Wasserman, IT Specialist (E)	N	Network & computing, redundant communications	1	NA	$7,612.00	12	$91,344
Peggy Wittie, Epidemiologist (E)	N	Coordinates epidemiology services and disease investigation	0.8	NA	$6,626.00	12	$63,610
Jillian Nelson, Epidemiology Analyst (E)	N	Performs disease & contact investigations, influenza surveillance, rabies PEP distribution	1	NA	$3,698.00	12	$44,376
Joann Gilbride, Administrative Assistant, Epi (E)	N	Tracks & maintains documentation for Epidemiology team	1	NA	$3,159.00	12	$37,908
							$0
							$0
							$0
							$0
							$0
							$0
					TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS		$0
					SalaryWage Total		$379,282

FRINGE BENEFITS	**Itemize the elements of fringe benefits in the space below:**
FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($765 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 0.135), Supplement Death Benefit (salary x .003), Unemployment Insurance (salary x 0.001); PHEM Planner not opted for medical/dental/RX	

	Fringe Benefit Rate %	30.13%
	Fringe Benefits Total	$114,276

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: **Collin County**

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
Quarterly PHEP Contractor Meeting	Contractor meeting conducted by DSHS	Austin, TX	2 days/1 employee	Mileage	$300
				Airfare	$0
				Meals	$100
				Lodging	$200
				Other Costs	$0
				Total	$600
Public Health Preparedness Summit	Conference for public health and emergency preparedness professionals	Anaheim, CA	5 days/1 employee	Mileage	$50
				Airfare	$450
				Meals	$250
				Lodging	$650
				Other Costs	$100
				Total	$1,500
i2 Americas User Conference 2013	Annual i2 analysis and training conference for IT Specialist	Washington, D.C.	3 days/1 employee	Mileage	$50
				Airfare	$450
				Meals	$150
				Lodging	$600
				Other Costs	$100
				Total	$1,350
IAEM-USA 61st Annual Conference	IAEM conference for stakeholders at all levels of government, the private sector, public health and related professions to exchange ideas on collaborating to protect lives and property from disaster.	Orlando, FL	5 days/ 1 employee	Mileage	$50
				Airfare	$450
				Meals	$250
				Lodging	$650
				Other Costs	$100
				Total	$1,500
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $4,950

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Out of office meetings, seminars, exercises, training, including day travel within DFW metroplex. Will be utilized by all BT funded staff.	2100	$0.565	$1,187	$50	$1,237
Short seminars, conferences, meetings within state of Texas. Will be utilized by all BT funded staff.	1000	$0.565	$565	$50	$615
			$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 $1,852

Other / Local Travel Costs: $1,852 Conference / Workshop Travel Costs: $4,950 **Total Travel Costs:** $6,802

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

Revised: 1/27/2012

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent: **Collin County**

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
				$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**

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
Office Supplies	Clipboards, paper, writing utensils, labels, etc. (approximately $575/FTE)	$4,000
POD Supplies	Various medical and non-medical supplies for each of 27 deployable POD kits (approximately $75/POD kit)	$2,000
Grant Program Supplies	Gloves, masks, crowd control posts, signs, etc., as needed to support various deliverables, including Responder Safety and Health, Mass Prophylaxis operations, dispensing models other than open PODs. Also includes alpha or first responder POD planning not covered by POD Supplies. Medical supplies ~$1,000 and non-medical office-type supplies ~$1,000; specific quantities or items are not finalized at this time	$2,000
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$8,000**

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: **Collin County**

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
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						$0

Total Amount Requested for CONTRACTUAL: $0

Revised: 1/27/2012

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: **Collin County**

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	Purpose & Justification	Total Cost
ATT Wireless Cell Phone	Cellular phone service (1 user, $37/month, 12 months)	$444
ATT Wireless Treo Service	Phone/data service (5 users, ~$86/month, 12 months)	$5,184
Conference Registration Fee	Registration fees for Public Health Summit ($600/person, 1 person), i2 Americas Conference ($300/person, 1 person), and IAEM-USA 61st Annual Conference ($600/person, 1 person)	$1,500
Facility Rental Fee	Facility rental fees associated with training classes/events (1 event @ $150/ea as one-time payment)	$150
Language Line	Translation services for non-English speaking clients	$1,250
Outreach	Annual budget for MRC recruitment and outreach materials, including print advertising	$1,000
Printing and Communication Materials	Printing fee for SNS brochures & materials	$117
Public Health Responder Identification Clothing	Provide the preparedness/first responder staff with identifable team shirts/jackets/hats to be used in exercise and drill activities and in real time response events (~$50/shirt, 2 shirts, 2 employees)	$100
Storage Space	Annual lease (1592 sq ft for $12/sq ft) for response kits and materials storage	$19,104
Subscriptions/References	Reference and other materials for Health Care Services (3 reference items @ ~$250/ea; 1 subscription item @ ~$750/ea)	$1,500
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Revised: 1/27/2012

Total Amount Requested for Other:	**$30,349**

FORM I - 7 Indirect Costs

Legal Name of Respondent: **Collin County**

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)

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:**

SUPPLEMENTAL and MATCH FORMS INSTRUCTIONS

The budget templates include a SUPPLEMENTAL and a MATCH page (one per budget category) that follow are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template. The MATCH pages (one per budget category) are intended to record the required match will be utilized to list detail information for the required match.
The amounts on each supplemental template will automatically populate from the templates and will be inserted on the last line of the primary budget template.
The amounts on each match template will automatically populate from the templates and will be inserted in column labeled "Local Funding Sources (5)"

The SUPPLEMENTAL and MATCH budget templates are:

Form I-1a Personnel Supplemental
Form I-2a Travel Supplemental
Form I-3a Equipment Supplemental
Form I-4a Supplies Supplemental
Form I-5a Contractual Supplemental
Form I-6a Other Supplemental

Form I-1b Personnel Match
Form I-2b Travel Match
Form I-3b Equipment Match
Form I-4b Supplies Match
Form I-5b Contractual Match
Form I-6ba Other Match

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

Legal Name of Respondent: **Collin County**

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
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$0

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

Legal Name of Respondent: **Collin County**

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
MATCH - Homeland Security Director (E)	N	Oversees Homeland Security Department and PHEP team	0.07	NA	$10,854.00	12	$9,117
MATCH - Accountant I (E)	N	Completes FSRs and maintains fiscal auditing documentation	0.07	NA	$4,465.00	12	$3,751
MATCH - Buyer, IT, Other County Staff	N	Supports PHEP team	0.05	NA	$4,465.00	12	$2,679
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$15,547

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

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($765 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 0.135), Supplement Death Benefit (salary x .003), Unemployment Insurance (salary x 0.001)

Fringe Benefit Rate %	28.85%
Fringe Benefits Total	$4,486

FORM I-2: TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County**

Conference / Workshop Travel Costs

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

Total for Conference / Workshop Travel $0

Revised: 1/27/2012

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0

Total for Other / Local Travel $0

Other / Local Travel Costs: $0

Conference / Workshop Travel Costs: $0

Total Travel Costs: $0

Revised: 1/27/2012

FORM I-2: TRAVEL Budget Category Detail Form (Match)

Legal Name of Respondent: Collin County

Conference / Workshop Travel Costs

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

Total for Conference / Workshop Travel $0

Revised: 1/27/2012

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0

Total for Other / Local Travel $0

Other / Local Travel Costs: $0

Conference / Workshop Travel Costs: $0

Total Travel Costs: $0

Revised: 1/27/2012

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Supplemental)

Legal Name of Respondent: **Collin County**

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
				$0
				$0

Total Amount Requested for Equipment: **$0**

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Match)

Legal Name of Respondent: **Collin County**

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
				$0
				$0

Total Amount Requested for Equipment: **$0**

Revised: 1/27/2012

FORM I-4: SUPPLIES Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County**

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 (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost

Total Amount Requested for Supplies: **$0**

Revised: 1/27/2012

FORM I-4: SUPPLIES Budget Category Detail Form (Match)

Legal Name of Respondent: **Collin County**

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 (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost

Total Amount Requested for Supplies: **$0**

Revised: 1/27/2012

FORM I-5: CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County**

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 de

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
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0

Total Amount Requested for CONTRACTUAL: $0

Revised: 1/27/2012

FORM I-5: CONTRACTUAL Budget Category Detail Form (Match)

Legal Name of Respondent: **Collin County**

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 de

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
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0

Total Amount Requested for CONTRACTUAL: $0

Revised: 1/27/2012

FORM I-6: OTHER Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County**

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

Total Amount Requested for Other: **$0**

Revised: 1/27/2012

FORM I-6: OTHER Budget Category Detail Form (Match)

Legal Name of Respondent: **Collin County**

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost
MATCH - Volunteer Activities	MRC volunteer training and events participation ($22.57/hour - calculated from Independent Sector - for 1500 hours of service)	$33,855

Total Amount Requested for Other: **$33,855**

Revised: 1/27/2012