TEXAS Department of State Health Services

FY2015

Cities Readiness Initiative

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: ☐
County: ☑
Other Political Subdivision: ☐

Click on appropriate box

Project Period

Start Date: 9/1/2014
End Date: 8/31/2015

Counties Served

County(ies) Served: Collin County

Amount of Funding Allocated: $ 126,633.00

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	Greg Huffman			Mailing Address (street, city, county, state, & zip):
Phone:	(214) 491-6892	Ext:		
Fax:	(972) 548-4747			
E-mail:	ghuffman@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				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 (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	$88,207	$85,488			$2,719	
B. Fringe Benefits	$35,538	$34,826			$712	
C. Travel	$1,992	$1,992			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$1,400	$1,400			$0	
F. Contractual	$0	$0			$0	
G. Other	$12,170	$2,927			$9,243	
H. Total Direct Costs	$139,307	$126,633	$0	$0	$12,674	$0
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$139,307	$126,633	$0	$0	$12,674	$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**	**$88,207**	**$88,207**	**Fringe Benefits**	**$35,538**	**$35,538**
	Travel	**$1,992**	**$1,992**	**Equipment**	**$0**	**$0**
	Supplies	**$1,400**	**$1,400**	**Contractual**	**$0**	**$0**
	Other	**$12,170**	**$12,170**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$139,307**	**Budget Total**	**$139,307**

If the Contractor is using Indirect Costs as Match, then enter the amount in Line 16, Column H.

Revised: 04/14/2014

FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent: **Collin County**

PERSONNEL Name + Functional Title	Vacant Y/N	Justification	FTEs	Certification or License (Enter NA if not required)	Estimated Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
Greg Huffman, CRI Coordinator (E)	N	Performs SNS and emergency preparedness activities; assists with MRC	1	NA	$3,562.00	12	$42,744
Rebecca Drekmann, MRC Coordinator (E)	N	Coordinate volunteers for SNS and emergency preparedness activites	1	NA	$3,562.00	12	$42,744
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS		$0
					SalaryWage Total		$85,488

FRINGE BENEFITS	**Itemize the elements of fringe benefits in the space below:**	
FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($850 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 %	40.74%
	Fringe Benefits Total	$34,826

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	
Public Health Preparedness Summit	Conference for public health and emergency preparedness professionals	TBD	5 days/ 1 employee	Mileage	$50
				Airfare	$450
				Meals	$250
				Lodging	$650
				Other Costs	$100
				Total	$1,500
				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 $1,500

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 CRI funded staff.	500	$0.560	$280	$50	$330
Short seminars, conferences, meetings within state of Texas. Will be utilized by all CRI funded staff.	200	$0.560	$112	$50	$162
			$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 $492

Other / Local Travel Costs: $492 Conference / Workshop Travel Costs: $1,500 **Total Travel Costs:** $1,992

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**

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 Cost
				$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: 3/25/2014

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 Provide estimated quantity and cost	Purpose & Justification	Total Cost
Office Supplies	Clipboards, paper, writing utensils, labels, etc. (approximately $200/FTE)	$400
POD Supplies	Various medical and non-medical supplies for each of 10 primary deployable POD kits (approximately $30/POD kit). These include additional POD signage inside the POD, external signage and drive-thru items (such as cones, safety lights, and small barriers), replacement of existing expired POD supplies (such as hand sanitizer and bandages), administrative supplies for drive-thru PODs (such as enclosed clipboards), and POD inventory supplies (such as inventory marking tools and supplies).	$300
Grant Program Supplies	Gloves, masks, crowd control posts, signs, etc., as needed to support various deliverables, including Mass Prophylaxis operations and dispensing models other than open PODs. Also includes alpha or first responder POD planning not covered by POD Supplies. Medical supplies ~$300 and non-medical office-type supplies ~$400; specific quantities or items are not finalized at this time	$700

TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		$0

Total Amount Requested for Supplies:	**$1,400**

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

Total Amount Requested for CONTRACTUAL: $0

Revised: 3/25/2014

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: **Collin County**

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
ATT Wireless	Phone/data service (2 users, $81.25/month, 12 months)	$1,950
Conference Registration Fees	Registration fees for Public Health Summit ($500/person, 1 person).	$500
Facility Rental Fee	Facility rental fees associated with training classes/events (2 events, $100 each event as one-time payment)	$200
Printing and Communication Materials	Printing fee for SNS brochures & materials	$277
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$2,927**

Revised: 3/25/2014

FORM I - 7 Indirect Costs

Legal Name of Respondent: **Collin County**

Total amount of indirect costs allocable to the project: **Amount:**

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 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)	Estimated 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)	Estimated Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
Eileen Prentice, MATCH - Accountant I (E)	N	Completes FSRs and maintains fiscal auditing documentation	0.05	NA	$4,532.00	12	$2,719
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$2,719

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

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($850 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 %	26.20%
Fringe Benefits Total	$712

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: 3/25/2014

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: 3/25/2014

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: 3/25/2014

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

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: 3/25/2014

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: 3/25/2014

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: 3/25/2014

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: 3/25/2014

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: 3/25/2014

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: 3/25/2014

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 ($23.40/hour, calculated from Independent Sector, for ~395 hrs of service)	$9,243

Total Amount Requested for Other: **$9,243**

Revised: 3/25/2014