Form A Face Page

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): **Check if address change** ☐

COLLIN COUNTY HEALTH CARE SERVICES, 825 N. MCDONALD, SUITE 145, MCKINNEY, TX 75069

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

COLLIN COUNTY AUDITOR'S OFFICE, 2300 BLOOMDALE ROAD, SUITE 3100 MCKINNEY, TX 75071

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

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

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

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

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

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

7) PROPOSED BUDGET PERIOD: **Start Date:** 09/01/2014 **End Date:** 08/31/2015

8) COUNTIES SERVED BY PROJECT:

COLLIN COUNTY

9) AMOUNT OF FUNDING REQUESTED: $119,622.00

10) PROJECTED EXPENDITURES

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

Yes ☐ No ☒

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

11) PROJECT CONTACT PERSON

Name: PATSY MORRIS
Phone: 972-548-5503
Fax: 972-548-5550
Email: pmorris@co.collin.tx.us

12) FINANCIAL OFFICER

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

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

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

Name: KEITH SELF
Title: COUNTY JUDGE
Phone: 972-548-4635
Fax: 972-548-4699
Email: keith.self@co.collin.tx.us

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

Keith Self

15) DATE

5/19/14

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 B: APPLICATION TABLE OF CONTENTS AND CHECKLIST

Legal Business Name of Respondent COLLIN COUNTY HEALTH CARE SERVICES

This form is provided as your Table of Contents and to ensure that the application is complete, proper signatures are included, and the required attachments have been submitted. Be sure to indicate page number.

FORM	DESCRIPTION	Included
A	Face Page - completed, and proper signatures and date included	X
B	Proposal Table of Contents and Checklist - completed and included	X
C	Contact Person Information - completed and included	X
D	Performance Measures	X
F	Budget Summary Form - completed and included (with most recently approved indirect cost agreement and letters of good standing if applicable)	X
G	Budget Category Detail Forms - completed and included	X

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	
Title:	ADMINISTRATOR		Street:	825 N. MCDONALD ST., SUITE 145
Phone:	972-548-5504	Ext:	City:	MCKINNEY
Fax:	972-548-5551		County:	COLLIN COUNTY
Email:	cblair@co.collin.tx.us		State, Zip:	TEXAS 75069
Contact:	PATSY MORRIS		Street:	825 N. MCDONALD ST., SUITE 145
Title:	HEALTH CARE COORDINATOR		City:	MCKINNEY
Phone:	972-548-5503	Ext:	County:	COLLIN COUNTY
Fax:	972-548-5550		State, Zip:	TEXAS 75069
Email:	pmorris@co.collin.tx.us			
Contact:			Street:	.
Title:			City:	
Phone:		Ext:	County:	
Fax:			State, Zip:	
Email:				
Contact:			Street:	
Title:			City:	
Phone:		Ext:	County:	
Fax:			State, Zip	
Email:				
Contact:			Street:	
Title:			City:	
Phone:		Ext:	County:	
Fax:			State, Zip	
Email:				

FORM D: PERFORMANCE MEASURES

The following performance measures will be used to assess, in part, Contractor's effectiveness in providing the services described in this Contract, without waiving the enforceability of any of the other terms of the Contract or any other method of determining compliance.

1. Conduct quarterly cohort reviews in accordance with DSHS TB and Refugee Health Services Branch cohort review schedule and submit appropriate documentation outlined in Tuberculosis Work Plan.

2. Cases, and suspected cases, of TB under treatment by Contractor shall be placed on timely and appropriate Direct Observed Therapy (DOT). If data indicates a compliance rate for this Performance Measure of less than 90%, 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 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.*
If data indicates a compliance rate for this Performance Measure of less than 87.5, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

3. 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. If data indicates a compliance rate 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;

4. Newly-reported cases of TB with Acid-fast Bacillis (AFB) positive sputum culture results will have documented conversion to sputum culture-negative within 60 days of initiation of treatment. If data indicates a compliance rate for this Performance Measure of less than 47%, then DSHS may (at its sole discretion) require additional measures be taken by contractor to improve the percentage, on a timeline set by DSHS;

5. 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 schedule provided herein. If fewer than 82% 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;

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

7. 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. If data indicates a compliance rate for this Performance Measure of less than 90%, 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. Newly-identified contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive TB case shall be evaluated for TB infection and disease. If data indicates a compliance rate 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;

9. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case and that are newly diagnosed with latent TB infection (LTBI) shall be started on timely and appropriate treatment. If data indicates a compliance rate 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;

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

11. Newly-reported TB patients that are older than 12-years-old and that have a pleural or respiratory site of disease shall have sputum AFB-culture results reported to DSHS according to the timelines for reporting initial and updated results given herein. If data indicates a compliance rate for this Performance Measure of less than 90.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

12. Increase the proportion of culture-confirmed TB cases with a genotyping result reported. If data indicates a compliance rate for this Performance Measure of less than 85%, 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 medical evaluation within 90 days of arrival. 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;

14. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB and who are diagnosed with latent TB infection (LTBI during evaluation in the US, increase the proportion who start treatment. Measure of less than 68%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS;

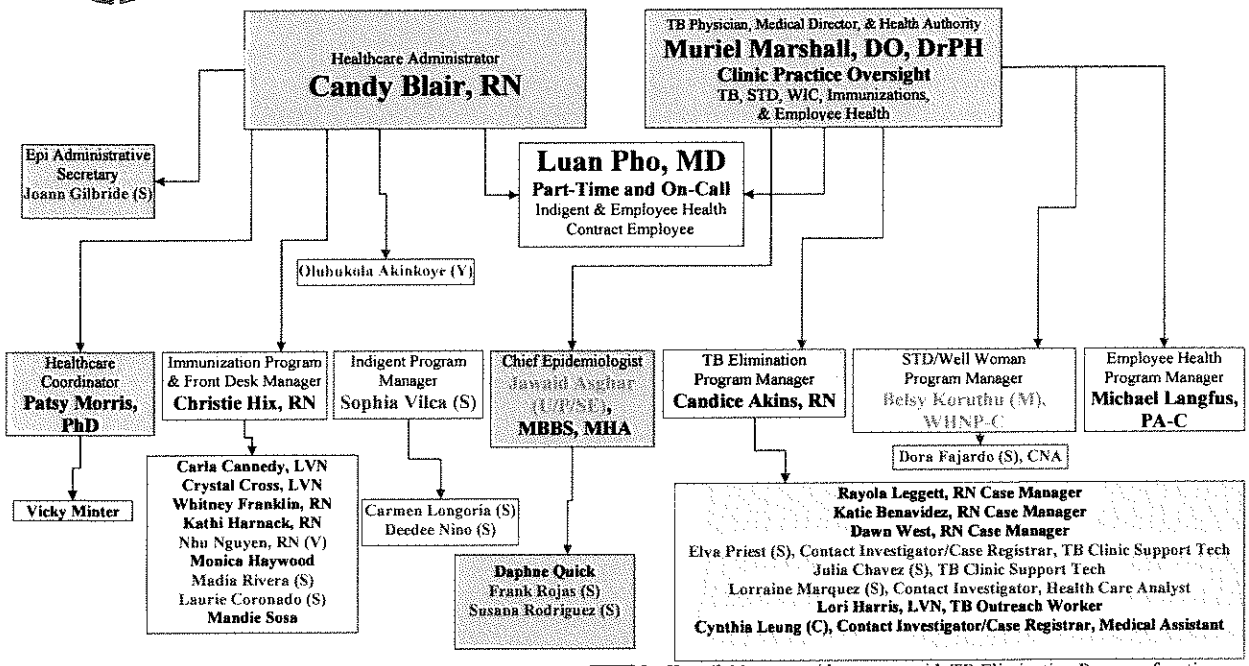
15. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB and who are diagnosed with latent TB infection (LTBI during evaluation in the US and started on treatment, increase the proportion who complete LTBI treatment. Measure of less than 70%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS; and

16. All reporting to DSHS shall be completed as described herein under Section I above and submitted by the deadlines given.

If the contractor fails to meet any of the performance measures, the CONTRACTOR shall furnish in the narrative report due February 13, 2015, a written explanation including a plan to meet those measures.

The TB and Refugee Health Services Branch shall calculate performance measures based on the information maintained in databases kept at the TB/HIV/STD/Viral Hepatitis Unit through limited scope audits or inspections, and scheduled program reviews of successful applicants.

COLLIN COUNTY HEALTH CARE SERVICES ORGANIZATIONAL CHART



TB Elimination Program Full Time Employees

Staff available to provide support with TB Elimination Program functions

(S) Bilingual staff members (Spanish) (V) Bilingual staff member (Vietnamese) (C) Bilingual staff member (Chinese, Mandarin, Cantonese)

(M) Bilingual staff member (Malayalam) (U/P/SE) Bilingual staff member (Urdu, Punjabi, Seraiki)

(Y) Bilingual staff member (Yoruba)

Updated 1/7/2014

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	$599,107	$80,011		$136,778	$19,474	$362,844
B. Fringe Benefits	$168,814	$22,403		$38,429	$5,453	$102,529
C. Travel	$1,386	$1,106		$280	$0	$0
D. Equipment	$0	$0		$0	$0	$0
E. Supplies	$3,946	$0		$3,946	$0	$0
F. Contractual	$18,502	$16,102		$2,400	$0	$0
G. Other	$0	$0		$0	$0	$0
H. Total Direct Costs	$791,755	$119,622	$0	$181,833	$24,927	$465,373
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$791,755	$119,622	$0	$181,833	$24,927	$465,373
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**	**$599,107**	**$599,107**	**Fringe Benefits**	**$168,814**	**$168,814**
	Travel	**$1,386**	**$1,386**	**Equipment**	**$0**	**$0**
	Supplies	**$3,946**	**$3,946**	**Contractual**	**$18,502**	**$18,502**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$791,755**	**Budget Total**	**$791,755**

*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
Public Health Nurse - Dawn West-E	N	Provides case management services	0.91	License	$4,737.00	12	$51,728
Medical Assistant - Cynthia Leung-E	N	Provides case registrar, case management and data base	0.91	NA	$2,590.00	12	$28,283
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$80,011

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 %	28.00%
Fringe Benefits Total	$22,403

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
Case Registrar Workshop	Annual training by DSHS - TB Department (Hotel $120/3 nights; meals-per diem rate; mileage 500@.56/per mile)	Austin	1 (4 days)	Mileage	$280
				Airfare	$0
				Meals	$164
				Lodging	$360
				Other Costs	$0
				Total	$804
				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 $804

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Travel for Blood draws at homes, contact investigation screenings, pick-up & drop off chest xrays films at hospitals and DOT	539	$0.560	$302		$302
			$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 $302

Other / Local Travel Costs: $302 **Conference / Workshop Travel Costs:** $804 **Total Travel Costs:** $1,106

Indicate Policy Used: **Respondent's Travel Policy** X **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/quote.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
None				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
			TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS	$0

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

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**
None		
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

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

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 co 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)
Prima Care	DOT services for TB patients after hours	Needed for TB patients after hours and on weekends	Monthly	100	$50.00
Envision	Chest X-rays	TB patients with positive skin test or blood test (12 per month @33.00 ea.)	Ea.	12	$396.00
Opthamologist	Vision Check	Needed for TB cases on toxic meds that affect vision	Ea.	13	$300.00
Infectious Disease Pharmacokinectics Lab	Assay-Serum Concentration Reports	Needed for TB patients to check drug serum levels to see how they are absorbing TB meds.	Ea.	5	$70.00
Envision	CT Scans	Needed for TB patients whose radiology reports are abnormal for chest xrays to rule out TB.	Ea.	6	$350.00
				TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	

Total Amount Requested for CONTRACTUAL:

ntractors as "To Be

TOTAL
$5,000
$4,752
$3,900
$350
$2,100
$0
$0
$0
$0
$0
$16,102

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

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
Elva Priest - DOT Worker - E	N	Provides DOT	0.43	NA	$3,774.00	12	$19,474
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$19,474

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 %	28.00%
Fringe Benefits Total	$5,453