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): **Check if address change** ☐

825 N. McDonald St., 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

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

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

9) AMOUNT OF FUNDING REQUESTED: $160,194.00

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:
Email: 972-548-4699

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

15) DATE 5/19/14

FORM B: Inter-Local APPLICATION CHECKLIST

Legal Name of applicant: COLLIN COUNTY HEALTH CARE SERVICES

This form is provided to ensure that the application is complete, proper signatures are included, and the required assurances, certifications, and attachments have been submitted.

FORM	DESCRIPTION	Included
A	Face Page completed, and proper signatures and date included	X
B	Application Checklist completed and included	X
C	Contact Person Information completed and included	X
D	Administrative Information completed and included (with supplemental documentation attached if required)	X
E	Organization, Resources and Capacity included	X
F	Performance Measures 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, Suite 145
Phone:	972-548-5504	Ext:	City:	McKinney, TX
Fax:	972-548-5550		County:	COLLIN
Email:	cblair@co.collin.tx.us		State, Zip:	TEXAS 75069
Contact:	PATSY MORRIS		Street:	825 N. McDonald, Suite 145
Title:	HEALTH CARE COORDINATOR		City:	MCKINNEY
Phone:	972-548-5503	Ext:	County:	COLLIN
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: 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.*

Legal Name of Applicant: COLLIN COUNTY HEALTH CARE SERVICES

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)	
2014-001394-00	
2014-001388-00	
2014-001266-00	
2014-001289-00	

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:

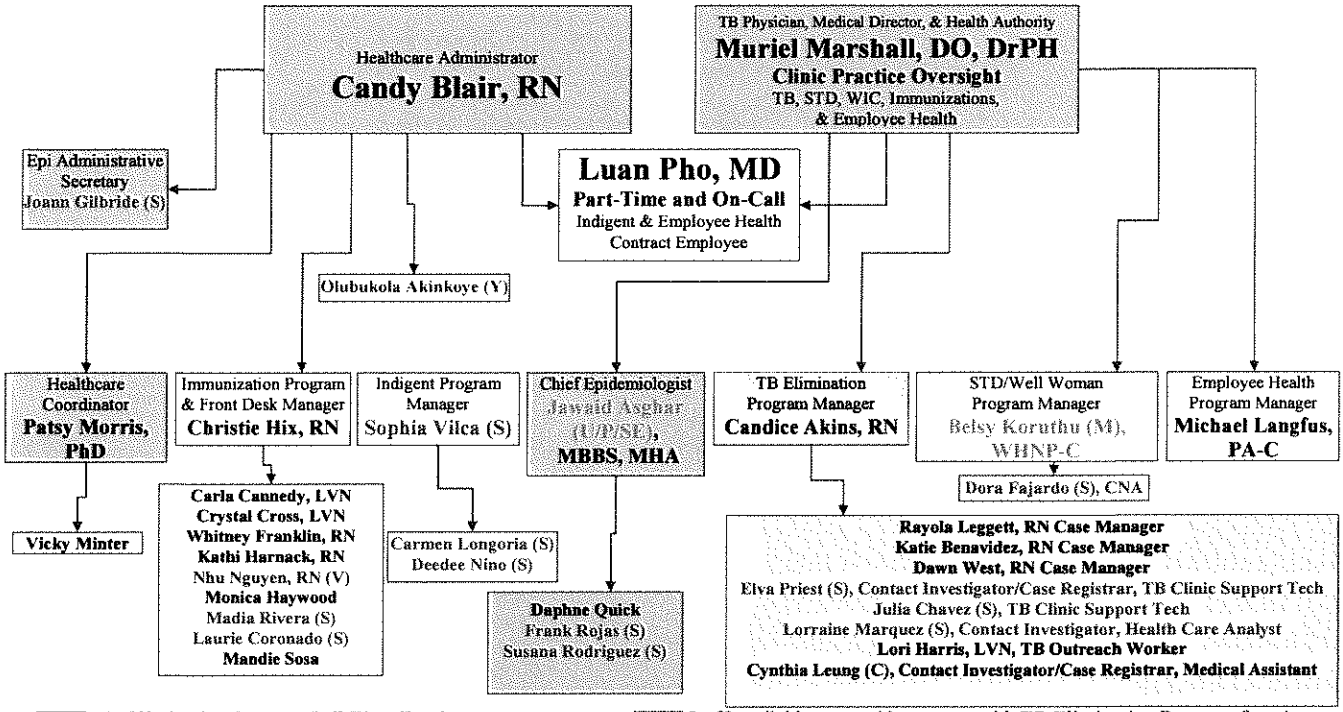
- Delinquent on any state, federal or other debt;
- Affiliated with an organization which is delinquent on any state, federal or other debt; or
- In default on an agreed repayment schedule with any funding organization?

☐ **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



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 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. Cases, and suspected cases, of TB under treatment by Contractor shall be placed on timely and appropriate Directly 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;

2. 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%, 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 reporting schedule provided in Section 1, B 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 in Section I, B-Reporting 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 (with schedule) to meet those measures. 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.

The TB and Refugee Health Services Branch shall calculate performance measurers 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.

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	$119,975	$80,011	$16,803	$25,190	$357,128
B. Fringe Benefits	$168,814	$33,593	$22,403	$4,836	$7,053	$100,929
C. Travel	$1,386	$280	$1,106		$0	$0
D. Equipment	$0	$0	$0		$0	$0
E. Supplies	$3,946	$3,946	$0		$0	$0
F. Contractual	$18,502	$2,400	$16,102		$0	$0
G. Other	$0	$0	$0		$0	$0
H. Total Direct Costs	$791,755	$160,194	$119,622	$21,639	$32,243	$458,057
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$791,755	$160,194	$119,622	$21,639	$32,243	$458,057
K. Program Income - Projected Earnings	$1,800	$756	$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
Katie Benavidez- Public Health Nurse	N	Provides direct TB services	0.73	License	$4,736.00	12	$41,487
Lorraine Marquez-Contact Investigator	N	Provides direct TB services	0.71	Certification	$3,629.00	12	$30,919
Lorie Harris-Outreach Worker	N	Provides direct TB services	0.7	NA	$3,036.00	12	$25,502
Julia Chavez-Medical Assistant	N	Provides direct TB services	0.71	Certification	$2,590.00	12	$22,067
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$119,975

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	$33,593

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	
None				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
				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 $0

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	500	$0.560	$280		$280
			$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 $280

Other / Local Travel Costs: $280 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** **$280**

Indicate Policy Used: **Respondent's Travel Policy** X **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 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
			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**
Medical Supplies - All supplies used in clinic for TB patients: blood draws for T-Spot testing, masks & sanitizer for TB protocol	Medical supplies used in TB clinic: (15 boxes of blood collection tubes @55.00=$825; Masks 40 boxes @25.00/bx=$1,000; hand sanitizer 12 btls @ $6.50 ea. = $78.00; butterflies for drawing blood -20 cases @$60/per case = 1,200	$3,103
Medical Supplies - all supplies used for TB patients for services and sanitizing. Need sharps to dispose of biohazard waste.	Antimicrobial Liq. Soap: 20 btls @$8.02 ea. = $160; Caviwipes Tub: 20 ea. @$7.09 ea.=$142.00; Diamond Grip Gloves Med. 10 bxs @$9.89 bx. = $99.00; Diamond Grip Gloves Lge-10bxs @$9.89 bx = $99; Vacutainer Needle Holder 10 bags @ $9.94 bg = $99.00; Sharps containers 3cs @ $61.20 case = $184	$783
Medical Supplies - TB supplies necessary for the administration of PPDs and blood draws.	Curity Alcohol preps 10 bxs @4:00 bx = $40.00; Coverlet strip pieces 20bxs @ 1:00 bx = $20	$60
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$3,946**

Revised: 1/27/2012

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)
Jerry Barnett	Pharmacist	Needed for TB patients	Monthly	12	$200.00
			TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS		

Total Amount Requested for CONTRACTUAL:

ntractors as "To Be

TOTAL
$2,400
$0
$0
$0
$0
$0
$0
$0
$0
$0
$2,400

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**
None		
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 1/27/2012

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:**

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
Rayola Leggett-Nurse E	N	Provides TB Services	0.42	License	$4,998.00	12	$25,190
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$25,190

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	$7,053