TEXAS Department of State Health Services

Department of State Health Services
FORM A: FACE PAGE

CONTRACTOR 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 75071

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:** 09/01/2015 **End Date:** 08/31/2016

8) COUNTIES SERVED BY PROJECT:

Collin County

9) AMOUNT OF FUNDING REQUESTED: $78,475.00

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: Joann Gilbride
Phone: 972-548-4707
Fax: 972-548-4441
Email: jgilbride@co.collin.tx.us

12) FINANCIAL OFFICER

Name: JEFF MAY
Phone: 972-548-4641
Fax: 972-548-4696
Email: jgilbride@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

3/23/15

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 respondent'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.** ***Please provide at least one (1) Emergency Contact as noted below.***

Emergency Contact:	Candy Blair	**Mailing Address (incl. street, city, county, state, & zip):**
Title:	Health Care Administrator	825 N. McDonald St., Suite 145
Phone:	972-548-5504	McKinney
Fax:	972-548-4441	Collin County
Email:	cblair@co.collin.tx.us	Texas 75069
Contact:	Joann Gilbride	**Mailing Address (incl. street, city, county, state, & zip):**
Title:	HC Coordinator	825 N. McDonald St., Suite 145
Phone:	972-548-4707	McKinney
Fax:	972-548-4441	Collin County
Email:	jgilbride@co.collin.tx.us	Texas, 75069
Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
Email:		
Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
Email:		
Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
Email:		

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
A. Personnel	$56,580	$56,580	$0	$0	$0	$0
B. Fringe Benefits	$19,961	$19,961	$0	$0	$0	$0
C. Travel	$987	$987	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$287	$287	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$660	$660	$0	$0	$0	$0
H. Total Direct Costs	$78,475	$78,475	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$78,475	$78,475	$0	$0	$0	$0
K. Program Income - Projected Earnings	$0	$0				

NOTE: The "Total Budget" amount for each Budget Category will have to be allocated (entered) manually among the funding sources. Enter amounts in whole dollars. After amounts have been entered for each funding source, verify that the "Distribution Total" below equals the respective amount under the "Total Budget" from column (1).

	Budget Catetory	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	**Personnel**	**$56,580**	**$56,580**	**Fringe Benefits**	**$19,961**	**$19,961**
	Travel	**$987**	**$987**	**Equipment**	**$0**	**$0**
	Supplies	**$287**	**$287**	**Contractual**	**$0**	**$0**
	Other	**$660**	**$660**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$78,475**	**Budget Total**	**$78,475**

*Letter(s) of good standing that validate the respondent's programmatic, administrative, and financial capability must be placed after this form if respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include funding from other state agencies in column 4 or Federal sources in column 3 that is not related to activities being funded by this DSHS project.

FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

PERSONNEL Functional Title + Code E = Existing or P = Proposed	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Epidemiologist 1 -E	N	State - Funded position for foodborne illness program	1	Certification	$4,715.00	12	$56,580
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$56,580

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

FICA/Medicare: $4,328; Employee Ins. 10,559; Long Term Disability 141: Short Term Disability 23; Long Term Care 180; Retirement 4,526; Supplemental Death Benefit 147; Unemployment Ins. 57

Fringe Benefit Rate %	35.28%
Fringe Benefits Total	$19,961

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	
Training/conference in Austin - Foodborne Illness Program	Training for updates; 470 miles @ 57.5; meals per diem $143; Hotel 3 nights @ $170/per night; tolls $7.	Austin, TX	3 days/1 Employee	Mileage	$270
				Airfare	$0
				Meals	$200
				Lodging	$510
				Other Costs	$7
				Total	$987
				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 FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $987

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
None			$0		$0
			$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 $0

Other / Local Travel Costs: $0 **Conference / Workshop Travel Costs:** $987 **Total Travel Costs:** $987

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

Revised: 7/6/2009

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
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**
General Office Supplies: 1 doz. pens @ $15.00; paper 1 cs, copier paper - $115.00; note pads 1 doz. - 29.87; envelopes - 1 bx. $103.99; post it notes - 14-pk. - $23.14.	Supplies needed for operation of the program.	$287
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		$0

Total Amount Requested for Supplies: **$287**

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates $100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly rate, unit rate, lump sum amount)	TOTAL
None						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for CONTRACTUAL: $0

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
Monthly Service - IPhone	Required for the cell phone - $55/per month. Employee is in the field a lot and cell phone is necessary.	$660
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		$0

Total Amount Requested for Other: **$660**

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:**