TEXAS Department of State Health Services

FY 2018/19 Request for Local Public Health Services Funds (LPHS)

Contents

1) Form A – Face Page
2) Contact Information Form
3) Project Service Delivery Plan
4) Template - FY18/19 LPHS Project Service Delivery Plan/Quarterly and Final Performance Report

Contract documents are due to DSHS on or before Friday, January 13, 2016 by COB @ via email to LocalPHTeam@dshs.state.tx.us

Please reference your entity's name in the subject line of your email.

(Example: XYZ Local Health Dept. FY18/19 RLSS/LPHS)

Please contact your contract manager at (512) 776-2181 for assistance in completing the FY18/19 RLSS/LPHS contract documents.

FY 2018/19 Local Public Health Services
FORM A - FACE PAGE

RESPONDENT INFORMATION

1) LEGAL NAME: COLLIN COUNTY HEALTH CARE SERICES

2) MAILING Address Information (include mailing address, street, city, county, state and zip code):

Collin County Health Care Services
825 N. McDonald Street, Suite 145
McKinney, TX 75069

3) PAYEE Mailing Address (if different from above):

Collin County Auditor's Office
2300 Bloomdale Road, Suite 3100
McKinney, TX 75071

4) Federal Tax ID No. (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or if an individual, **Social Security Number** (9 digit) : 756000873

*The vendor acknowledges, understands and agrees that the vendor'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.

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

- ☐ City
- ☒ Regions/Counties/LHD
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith-based Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

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

6) COUNTIES OR REGION SERVED BY PROJECT: **COLLIN**
See attached County/Region list.

7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: JOANN L. GILBRIDE Phone: 972-548-5503 Fax: 972-548-4441 E-mail: JGILBRIDE@CO.COLLIN.TX.US	X **LPHS** **$ 43,278**

The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications attached in **FORM E,** and will provide services in accordance with **25 Texas Administrative Code, §§37.51-37.65.** This document has been duly authorized by the governing body of the applicant and I (the person signing below) am authorized to represent the applicant.

8) AUTHORIZED REPRESENTATIVE	
Name: KEITH SELF Title: COUNTY JUDGE Phone: 972-548-4635 Fax: 972-548-4699 E-mail: KEITH.SELF@CO.COLLIN.TX.US	**9) DATE** 1/30/17

GENERAL INSTRUCTIONS FOR THE FACE PAGE

This form provides basic information about the applicant and the proposed project with the Department of State Health Services (DSHS), including the name of the authorized representative. It is the cover page of the proposal and is required to be completed. **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 applicant's proposal.

1) **LEGAL NAME** - Enter the legal name of the applicant.

2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and zip code.

3) **PAYEE MAILING ADDRESS** - Payee – Entity involved in a contractual relationship with applicant to receive payment for services rendered by applicant and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID/SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The vendor acknowledges, understands and agrees that the vendor'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.

5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the Texas Building and Procurement Commission or another entity.

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.

6) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties or region to be served by the project.

7) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.

8) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and e-mail address of the person authorized to represent the applicant. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

9) **DATE** - Enter the date this form is completed.

FY 2018/19 Local Public Health Services

Division for Regional and Local Health Services
Program Contact Information
Contract Term: September 1, 2017 through August 31, 2019

Legal Name of Applicant: COLLIN COUNTY HEALTH CARE SERVICES

This form provides information about appropriate program contacts in the applicant's organization. If any of the contact information changes during the term of the contract, please send written notification to the Regional and Local Health Service & Compliance Branch, Mail Code 1990, P.O. Box 149347, Austin, TX 78714 or email to ***LocalPHTeam@dshs.state.tx.us*** *.*

Director

Contact:	CANDY BLAIR	**Mailing Address (street, city, county, state, & zip):**
Title:	HEALTHCARE ADMINISTRATOR; CCHCS	825 N. McDonald Street, Suite 130
Phone:	972-548-5504	MCKINNEY
Fax:	972-548-4441	COLLIN COUNTY
E-mail:	cblair@co.collin.tx.us	TEXAS 75069

Financial Manager

Contact:	JANNA BENSON-CAPONERA	**Mailing Address (street, city, county, state, & zip):**
Title:	GRANT SUPERVISOR; AUDITOR'S OFFICE	2300 BLOOMDALE ROAD, SUITE 3100
Phone:	972-548-4638	MCKINNEY
Fax:	972-548-4643	COLLIN COUNTY
E-mail:	jbenson-caponera@co.collin.tx.us	TEXAS 75071

Contract Coordinator

Contact:	JOANN GILBRIDE	**Mailing Address (street, city, county, state, & zip):**
Title:	HEALTHCARE COORDINATOR; CCHCS	825 N. McDonald, Suite 130
Phone:	972-548-5503	MCKINNEY
Fax:	972-548-4441	COLLIN COUNTY
E-mail:	jgilbride@co.collin.tx.us	TEXAS 75069

Additional Staff

Contact:	EILEEN PRENTICE	**Mailing Address (street, city, county, state, & zip):**
Title:	GRANT ACCOUNTANT; AUDITOR'S OFFICE	2300 BLOOMDALE RD., SUITE 3100
Phone:	972-548-4796	MCKINNEY
Fax:	972-548-4751	COLLIN COUNTY
E-mail:	eprentice@co.collin.tx.us	TEXAS 75071

Additional Staff

Contact:		**Mailing Address (street, city, county, state, & zip):**
Title:		
Phone:		
Fax:		
E-mail:		

FY 2018/19 Request for Local Public Health Services Funds
Project Service Delivery Plan

Texas Department of State Health Services

Local Health Department: COLLIN COUNTY HEALTH CARE SERVICES

Contract Term: September 1, 2017 through August 31, 2019

Indicate in this plan how requested Local Public Health Services (LPHS) contract funds will be used to address a public health issue through essential public health services. The plan should include a brief description of the public health issue(s) or public health program to be addressed by LPHS funded staff, and measurable objective(s) and activities for addressing the issue. List only public health issues/programs, objectives and activities conducted and supported by LPHS funded staff. List at least one objective and subsequent required information for each public health issue or public health program that will be addressed with these contract funds. The plan must also describe a clear method for evaluating the services that will be provided, including identification of a specific evaluation standard, as well as recommendations or plans for improving essential public health services delivery based on the results of the evaluation. Complete the table below for each public health issue or public health program addressed by LPHS funded staff. (Make additional copies of the table as needed)

Public Health Issue: ***Briefly describe the public health issue to be addressed. Number issues if more than one issue will be addressed.***
TB – In recent years, the number of suspected and confirmed cases of TB, as well as those with TB infection (TBI), has steadily increased as our county population continues to grow. Consequently, there has been a corresponding increase need for Directly Observed Therapy (DOT) services in order to maintain the standard of care for TB treatment and elimination.

Essential Public Health Service(s): ***List the EPHS(s) that will be provided or supported with LPHS Contract funds***
EPHS#2 Diagnose and investigate community health hazards.

Objective(s): ***List at least one measurable objective to be achieved with resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc.)***
1.1 Offer patient DOT within the clinic as well as offsite DOT to all eligible active TB cases and TBIs.

Performance Measure: ***List the performance measure that will be used to determine if the objective has been met. List a performance measure for each objective listed above.***
CCHCS will provide a quarterly report detailing the number of patients receiving medication via DOT.

Activities ***List the activities conducted to meet the proposed objective. Use numbering system to designate match between issues/programs and objectives.***	**Evaluation and Improvement Plan** ***List the standard and describe how it is used to evaluate the activities conducted. This can be a local, state or federal guideline.***	**Deliverable** ***Describe the tangible evidence that the activity was completed.***
CCHCS will provide patient DOT within the clinic as well as provide offsite DOT to all eligible active TB cases and TBIs.	CCHCS will collect and review data on a monthly basis to track DOT provided to patients onsite at the clinic and offsite.	CCHCS will provide a report to LPHS each quarter describing the DOT provided to eligible patients.

The following **EXAMPLE** of a Service Delivery Plan is offered as a guide for completing the table to address your specific public health issue(s).

Public Health Issue: ***Briefly describe the public health issue to be addressed. Number issues if more than one issue will be addressed.***

The local community lacks an accurate assessment of the local public health system in order to strategically plan and improve the essential public health services provided in the community.

Essential Public Health Service(s): ***List the EPHS(s) that will be provided or supported with LPHS Contract funds***

EPHS (9) Evaluate effectiveness, accessibility and quality of personal and population-based health services.

Objective(s): ***List at least one measurable objective to be achieved with resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc.)***

Objective 1.1 By the end of the 2nd quarter FY18, all LHD's funded through LPHS Contract dollars, will have conducted the CDC National Public Health Performance Standards Local Public Health System Performance Assessment Instrument (LPHSPAI).

Performance Measure: ***List the performance measure that will be used to determine if the objective has been met. List a performance measure for each objective listed above.***

Performance Measure – Based on LPHSPAI results, local health departments will submit a draft Service Delivery Plan to be completed by end of 3rd Quarter FY18.

Activities *List the activities conducted to meet the proposed objective. Use numbering system to designate match between issues/programs and objectives.*	**Evaluation and Improvement Plan** *List the standard and describe how it is used to evaluate the activities conducted.*	**Deliverable** *Describe the tangible evidence that the activity was completed.*
1.1.1 Participate in training offered by the state. 1.1.2 Identify necessary partners who will take part in conducting the LPHSPAI instrument. 1.1.3 Conduct LPHSPAI with identified partners. 1.1.4 Submit LPHSPAI data to the CDC for processing. 1.1.5 Gather CDC generated report on local assessment.	1.1.1 LHD's will plan and implement the LPHSPAI instrument in the designated communities no later than March 31st, 2018. 1.1.2 LPHSPAI results will be incorporated into the FY18 Service Delivery Plans.	1.1.1 LPHSPAI data analysis report will be obtained from CDC.

Texas Department of State Health Services
FY 2018/19 Local Public Health Services Funds
Project Service Delivery Plan
Quarterly and Final Performance Report
Contract Term: September 1, 2017 through August 31, 2019

Local Health Department:	**Contact:**	**Contact Phone:**
Address: *Include City, State, Zip*		
Contact Email:		**Date:**

Quarterly reports must be completed and submitted by the dates shown below. Complete the report table by providing the status of contract activities, identifying barriers to completing the activities, and listing deliverables. This report form should be completed cumulatively (each quarter's report added on to the previous report) and submitted to the Contract Manager, Regional and Local Health Services & Compliance Branch at: LocalPHTeam@dshs.state.tx.us. For technical assistance or questions contact the Contract Manager at (512)776-2181, or email at LocalPHTeam@dshs.state.tx.us. Please note that the **4th Quarter Report** must also include the **Final Report** with information to document results from the evaluation of services and a plan for improving the services.

*This report is designed to **"tab"** through the items to complete all of the sections. Indicate the reporting Quarter by clicking on the appropriate gray box.*

	Reporting Periods	Report Due Date
☐ 1st Quarter	September 1st thru November 30th	December 31st
☐ 2nd Quarter	December 1st thru February 28th	March 31st
☐ 3rd Quarter	March 1st thru May 31st	June 30th
☐ 4th Quarter/Final Report	June 1st thru August 31st (Qtr)/September 1st thru August 31st (Final)	September 30th

Public Health Issue(s): *Briefly describe the public health issue to be addressed. Number issues if more than one issue is addressed.*
Objective(s): *List the measurable objective(s) to be achieved by using resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc)*
Local Health Department:

	Activity – *list each activity conducted to meet the objective. Use numbering system to designate match with objectives and issues.*	**Status of Activity** *Provide status of each activity for the reporting quarter*	**Barriers to conducting activities:** *List any problems or barriers encountered that impact your ability to conduct or complete the activity*	**Deliverables:** *List the deliverable that provides tangible evidence that the activity was completed (4th quarter only)*
Q1				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Beginning with the Q2 report, incorporate improvement activities listed in the Project Service Delivery Plan. Please specify if these improvement activities will replace or amend any of the activities listed in the Q1 Report.				
Q2				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Q3				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Q4				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			

Texas Department of State Health Services
FY 2018/19 Local Public Health Services Funds
Project Service Delivery Plan
Quarterly and Final Performance Report

FINAL REPORT		
Local Health Department:		
The information requested below should be completed and submitted **ONLY** *with the 4th Quarter's report after the project period is completed. Duplicate the table below as needed for each objective listed in the FY 2018/19 Service Delivery Plan.*		
Objective: *List each objective outlined in the Service Delivery Plan.*	**Status:** *Document whether or not the objective was achieved*	**Comments:** *Provide an explanation if objective was not met*

Evaluation Results and Improvement Plan: *Describe the findings from the evaluation of project. List activities that will be conducted during the next contract term to improve the essential public health services or meet the objective. Also, include a plan for improving or amending activities for objectives that were not met during this contract term.*

Evaluation Standard:

Evaluation Activities:

Results/Findings:

Improvement Plan:

NOTICE

Refer to 2nd Excel file via email for DSHS Categorical Budget Forms

General Instructions for Completing Budget Forms
DSHS Costs Only Budgeted on Detail Category Pages

(Examples and instructions for completing the Budget Category Detail Templates are in a separate Excel file located under Templates for Cost Reimbursement Budgets located at :
http://www.dshs.state.tx.us/grants/forms.shtm

* Enter the legal name of your organization in the space provided for "Legal Name of Respondent" on Form I -Budget Summary; doing so will populate the budget category detail templates with your organizations name.

* Complete each budget category detail template. Instructions for completing each budget category detail template are in a separate document. If a primary budget category detail template does not accommodate all items in your budget, use the respective supplemental budget template at the end of this workbook. The total of each supplemental category detail budget template will automatically populate to the last line of the respective primary budget category template.

* After you have completed each budget category detail form, go to Form I-Budget Summary and input other sources of funding manually (if any) in Columns 3 - 6 for each budget category.

* Refer to the table below the budget template table to verify that the amounts distributed ("Distribution Total") in each budget category equals the "Budget Total" for each respective category. Next, verify that the overall total of all distributions ("Distribution Totals") equals the Budget Total.

* Enter the total amount of "Program Income" anticipated for this program in row "K" under the "Total Budget" column (1). The total program income budgeted will be automatically allocated to each funding source based on the percentage of funding of the total budget. Information on program income is available in the DSHS Contractors Financial Procedures Manual located at the following web site: http://www.dshs.state.tx.us/contracts/

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	$714,817	$32,566	$69,463	$110,897	$501,891	$0
B. Fringe Benefits	$257,836	$10,531	$20,075	$32,160	$195,070	$0
C. Travel	$4,230	$181	$1,344	$1,705	$1,000	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$17,450	$0	$11,284	$4,166	$2,000	$0
F. Contractual	$7,400	$0	$5,000	$2,400	$0	$0
G. Other	$8,720	$0	$7,220	$1,500	$0	$0
H. Total Direct Costs	$1,010,453	$43,278	$114,386	$152,828	$699,961	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$1,010,453	$43,278	$114,386	$152,828	$699,961	$0
K. Program Income - Projected Earnings	$0	$0	$0	$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**	**$714,817**	**$714,817**	**Fringe Benefits**	**$257,836**	**$257,836**
	Travel	**$4,230**	**$4,230**	**Equipment**	**$0**	**$0**
	Supplies	**$17,450**	**$17,450**	**Contractual**	**$7,400**	**$7,400**
	Other	**$8,720**	**$8,720**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$1,010,453**	**Budget Total**	**$1,010,453**

*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
Program Manager - RN - E	N	Provides programmatic oversight and programmatic accountability	0.22	License	$6,167.88	24	$32,566
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$32,566

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

FICA/Medicare: 7.65%; Employee Insurance: $1050 monthly per employee; long-term disability: .26%; short-term disability: $3.20; long-term care based on employee election; retirement: 8.5%; Supplemental Death benefit: .25%; Unemployment Insurance: .1%

Fringe Benefit Rate %	32.34%
Fringe Benefits Total	$10,531

Revised: 7/6/2009

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	
				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 FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Revised: 7/6/2009

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)
Local travel to offsite patient visits, physician offices, trainings, etc…(Other Costs are toll charges)	300	$0.535	$161	$20	$181
			$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 $181

Other / Local Travel Costs: $181 Conference / Workshop Travel Costs: $0 **Total Travel Costs:** $181

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 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
TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS				$0

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

Revised: 7/6/2009

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		$0
		$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: **$0**

Revised: 7/6/2009

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

Revised: 7/6/2009

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		$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: **$0**

Revised: 7/6/2009