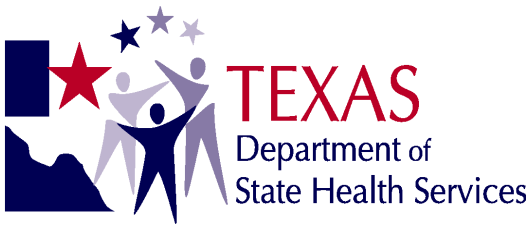

FY2021

TB FEDERAL

Applicant Information

Legal Name of Applicant Agency:	COLLIN COUNTY
Mailing Address:	
Street / PO Box:	825 N. MCDONALD #130
City:	MCKINNEY, TX
Zip:	75069
Payee Name:	COLLIN COUNTY
Payee Mailing Address:	
Street / PO Box:	825 N. MCDONALD #130
City:	MCKINNEY, TX
Zip:	75069
State of Texas Comptroller Vendor ID # (9 digit + 3 digit mail code)**:**	
DUNS # (9 digits required for subrecipient contractors)**:**	

Type of Entity (Choose one)

City:	☐	Click on appropriate box
County:	☑	
Other Political Subdivision:	☐	

Project Period

Start Date:	1/1/2021
End Date:	12/31/2021

Counties Served

County(ies) Served:	COLLIN
Amount of Funding Allocated:	**$114,386.00**

CONTACT PERSON INFORMATION

Legal Business Name: COLLIN COUNTY

This form provides information about the appropriate contacts in the contractor's organization in addition to those on the FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Management Unit.

Health Director/CEO: CANDY BLAIR
Phone: 972-548-5504 Ext:
Fax: 972-548-4441
E-mail: CBLAIR@CO.COLLIN.TX.US
Mailing Address (street, city, county, state, & zip): 825 N. MCDONALD #130, MCKINNEY, TX 75069

B-13/FSR Rep: LAURA THOMAS
Phone: 972-548-4511 Ext:
Fax: 972-548-4751
E-mail: LLTHOMAS@CO.COLLIN.TX.US
Mailing Address (street, city, county, state, & zip): 2300 BLOOMDALE RD, SUITE 3100, MCKINNEY, TX 75071

PHEP (HAZARDS) Program Leader:
Phone: Ext:
Fax:
E-mail:
Mailing Address (street, city, county, state, & zip):

SNS (CRI) Coordinator:
Phone: Ext:
Fax:
E-mail:
Mailing Address (street, city, county, state, & zip):

Authorized Signatory for **DocuSign**: CHRIS HILL
Phone: Ext:
Fax:
E-mail: CHILL@CO.COLLIN.TX.US
Mailing Address (street, city, county, state, & zip): 2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Additional Authorized Signatory for **DocuSign only if applicable (FFATA, Certs, etc)**
Phone: Ext:
Fax:
E-mail:

DocuSign "CC" Person: LAURA THOMAS
Phone: 972-548-4511 Ext:
Fax: 972-548-4751
E-mail: LLTHOMAS@CO.COLLIN.TX.US

Emergency Contact: JOANN GILBRIDE
Cell Phone: 214-326-1758 Ext:
Fax: 972-548-4441
E-mail: JGILBRIDE@CO.COLLIN.TX.US
Mailing Address (street, city, county, state, & zip): 825 N. MCDONALD #130, MCKINNEY, TX 75069

BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: **COLLIN COUNTY**

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)
A. Personnel	$74,687	$57,902		
B. Fringe Benefits	$31,320	$25,228		
C. Travel	$5,498	$5,498		
D. Equipment	$0	$0		
E. Supplies	$9,767	$9,767		
F. Contractual	$4,650	$4,650		
G. Other	$11,341	$11,341		
H. Total Direct Costs	$137,263	$114,386	$0	$0
I. Indirect Costs	$0	$0		
J. Total (Sum of H and I)	$137,263	$114,386	$0	$0
				Match Percentage

If the Contractor is using Indirect Costs as Match, then enter the amount in Li

Local Funding (Match) (5)	Other Funds **(6)**
$16,785	
$6,092	
$0	
$0	
$0	
$0	
$0	
$22,877	$0
$22,877	$0
20.00%	

ne 16, Column H.

PERSONNEL Budget Category Detail Form

Legal Name of Respondent: **COLLIN COUNTY**

PERSONNEL Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)	Estimated Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
Public Health Nurse - Dawn West-E	N	Provides TB case management services as a registered nurse	0.5	License	$6,242.14	12	$37,453
Medical Assistant - Cynthia Leung-E	N	Serves as TB case registrar, performing TB data collection and reporting duties	0.51	N/A	$3,341.35	12	$20,449
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS			$0
					SalaryWage Total		$57,902

FRINGE BENEFITS	**Itemize the elements of fringe benefits in the space below:**			
FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1200 for medical/dental/RX and $4.95 for term life per month), Long Term Disability (salary x 0.0024), Short Term Disability $2.10/month, Long Term Care $30.08/month, Retirement (salary x 0.08), Unemployment Insurance (salary x 0.001)				
Total Number of FTEs:	**1.01**		Fringe Benefit Rate %	43.57%
			Fringe Benefits Total	$25,228

TRAVEL Budget Category Detail Form

Legal Name of Respondent: **COLLIN COUNTY**

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days & Employees
Case Registrar Workshop (Cynthia Leung)	Annual training by DSHS - TB Department (Hotel $114 x 3 nights; meals-per diem rate-$41; mileage 505 mi. x.575/per mile)	Austin	1 employee (4 days)
DSHS Annual or Mandatory TB Training (Cynthia Leung, Dawn West, Elva Priest)	Annual training by DSHS - TB Department (Hotel $118 x3 nights; meals-per diem rate-$41; mileage 505 x .575 per mile)	Austin	3 employees (4 days)
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS			

Total for Conference / Workshop

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)
Out of office meetings, seminars, exercises, training, including day travel within DFW metroplex. Will be utilized by all grant funded staff.	3000	$0.575	$1,725	
Short seminars, conferences, meetings within state of Texas. Will be utilized by all grant funded staff.	1970	$0.575	$1,133	
			$0	
			$0	
			$0	
			$0	
			$0	
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS				

Total for Other / Loca

Other / Local Travel Costs: $2,858 Conference / Workshop Travel Costs: $2,640 **Total Trav**

Indicate Policy Used: Respondent's Travel Policy State of Te

Travel Costs	
Mileage	$290
Airfare	$0
Meals	$164
Lodging	$342
Other Costs	$0
Total	$796
Mileage	$290
Airfare	$0
Meals	$492
Lodging	$1,062
Other Costs	$0
Total	$1,844
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
	$0

Travel $2,640

Total (a) + (b)
$1,725
$1,133
$0
$0
$0
$0
$0
$0

al Travel	$2,858
vel Costs:	$5,498

xas Travel Policy	

EQUIPMENT AND CONTROLLED ASSETS Budget Categ

Detail Form

Legal Name of Respondent: **COLLIN COUNTY**

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order/quote.

Description of Item	Purpose & Justification
NONE	
TOTAL FROM EQUIPMENT SUPPI	

Total Amount Requested for

Revised: 3/25/2014

gory

Number of Units	Cost Per Unit	Total Cost
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
LEMENTAL BUDGET SHEETS		$0

' Equipment: **$0**

SUPPLIES

Legal Name of Respondent:

Itemize and describe each supply item and provide an estimated quar
be categorized by each general type (e.g., office, computer, medical, edu

Description of Item Provide estimated quantity and cost
General Office Supplies-Office Depot; ($283.33/mo X 12 mo = $3,400)
Reference Materials; ($155.58/mo X 12 mo = $1,867)
Printed Materials; ($41.66/mo X 12 mo = $500)

S Budget Category Detail Form

COLLIN COUNTY

ıtity and cost (i.e. #of boxes & cost/box) if applicable. Provide a justification for each supply item. Costs may ucational, etc.)

Purpose & Justification	Total Cost
Paper, pens, binders, highlighters, binder clips; other general supplies used for cohort review	$6,400
Educational journals/books for TB clinicians and/or education for community health care providers	$1,867
Mass printing of educational handouts for patients related to TB infection or TB diseases	$1,500
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$9,767**

CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: **COLLIN COUNTY**

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the serv
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 a

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)
Prima Care	DOT services for TB patients after hours	Needed for TB patients to receive medication after hours and on weekends	Unit
		TOTAL FROM CONTRACTUAL SUF	

Total Amount Requested

/ice to be contracted and show contractors as "To Be
ttached behind this form.

# of Payments	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL COST
93	$50.00	$4,650
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
PPLEMENTAL BUDGET SHEETS		$0

for CONTRACTUAL: $4,650

OTHER COS

Legal Name of Respondent:

Description of Item Include quantity and cost/quantity
Language Line ; ($208.33/mo X 12 mo = $2,500)
Patient Transportation ; ($416.66/mo X 12 mo = $5,000)
Monthly AT&T Service --Mifi/Hot Spot ; ($55/month X 12 months X 2 existing mifi devices)
Conference Registration ; (3 employees X $166.66 registration fees = $500)

TS Budget Category Detail Form

COLLIN COUNTY

Purpose & Justification	Total Cost
Translation services for patients to provide education, information about evaluation and treatment, and contact investigations	$4,521
Transporting patients to and from office visits and radiology appointments for public health purposes	$5,000
Required for wireless connectivity of tablet used offsite for public health monitoring of patients through videoconferencing	$1,320
Registration fees for TB trainings for continuing education for employees	$500
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$11,341**

Indirect Costs

Legal Name of Respondent: **COLLIN COUNT**

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

Indirect costs are based on (mark the statement that is applicable):

The respondent's most recent indirect cost rate approved by a federal cognizant agency or state single audit coordinating agency. Expired rate agreements are not acceptable. Attach a copy of the rate agreement to this form (Form I - 7 Indirect)

RATE:
BASE:

Applies only to governmental entities . The respondent's current central service cost rate or indirect cost rate. 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.

GO TO PAGE 2 (below)

If using an central service or indirect cost rate, identify the types of costs that are included (I

Organizations that do not use an indirect cost rate and governmental entities with only a central serv
allocated as indirect costs and the methodology used to allocate these costs in the space provided b
Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the t
the allocation methodology, and the allocation base:**

ry

Costs

being allocated) in the rate:

vice rate must identify the types of costs that will be
below. The costs/methodology must also be disclosed in
ypes of costs that are being allocated as indirect costs,

SUPPLEMENTAL and MATCH FORMS INSTRUCTIONS

The budget templates include a SUPPLEMENTAL and a MATCH page (one per budget category) that are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template. The MATCH pages (one per budget category) are intended to record the required match will be utilized to list detail information for the required match.

The amounts on each supplemental template will automatically populate from the templates and will be inserted on the last line of the primary budget template.

The amounts on each match template will automatically populate from the templates and will be inserted in column labeled "Local Funding Sources (5)"

The SUPPLEMENTAL and MATCH budget templates are:

Personnel Supplemental
Travel Supplemental
Equipment & Controlled Assets Supplemental
Supplies Supplemental
Contractual Supplemental
Other Costs Supplemental

Personnel Match
Travel Match
Equipment & Controlled Assets Match
Supplies Match
Contractual Match
Other Costs Match

PERSONNEL Budget Category Detail Form (Supplemer

Legal Name of Respondent: **COLLIN COUNTY**

PERSONNEL Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)
			0.00	

ntal)

Estimated Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
SalaryWage Total		$0

PERSONNEL Budget Category Detail Form (Match)

Legal Name of Respondent: **COLLIN COUNTY**

PERSONNEL Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)
Elva Priest - DOT Worker - E	N	Provides DOT to TB Patients	0.29	NA

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

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1300 for medical/dental/RX and $4.95 f
Long Term Disability (salary x 0.0024), Short Term Disability $2.10/month, Long Term Care $30.08/month, Retirement
Unemployment Insurance (salary x 0.001)

	Fringe
	Fringe

)

Estimated Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
$4,823.37	12	$16,785
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
SalaryWage Total		$16,785

or term life per month), : (salary x 0.08),	
Benefit Rate %	36.30%

Benefits Total	$6,092

TRAVEL Budget Category Detail Form (Supple

Legal Name of Respondent: **COLLIN COUNTY**

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)

Total for Conference

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	
			$0	
			$0	
			$0	

			$0	
			$0	
			$0	
			$0	
			$0	
			$0	

Total fo

Other / Local Travel Costs: $0

Conference / Workshop Travel Costs: $0

ɛmental)

Number of: Days & Employees	Travel Costs	
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0

/ Workshop Travel $0

Other Costs (b)	Total (a) + (b)
	$0
	$0
	$0

	$0
	$0
	$0
	$0
	$0
	$0

r Other / Local Travel	$0
Total Travel Costs:	$0

TRAVEL Budget Category Detail Form (Ma

Legal Name of Respondent: **COLLIN COUNTY**

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)

Total for Conference

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	
			$0	
			$0	
			$0	

			$0	
			$0	
			$0	
			$0	
			$0	
			$0	

Total fo

Other / Local Travel Costs: $0

Conference / Workshop Travel Costs: $0

ıtch)

Number of: Days & Employees	Travel Costs	
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	Total	$0

/ Workshop Travel $0

Other Costs (b)	Total (a) + (b)
	$0
	$0
	$0

	$0
	$0
	$0
	$0
	$0
	$0

r Other / Local Travel	$0
Total Travel Costs:	$0

EQUIPMENT AND CONTROLLED ASSETS Budget Categ

Detail Form (Supplemental)

Legal Name of Respondent: **COLLIN COUNTY**

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

Description of Item	Purpose & Justification

Total Amount Requested for

gory

lefinition and detailed instructions to complete this

Number of Units	Cost Per Unit	Total
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0

Equipment: **$0**

EQUIPMENT AND CONTROLLED ASSETS Budget Categ

Detail Form (Match)

Legal Name of Respondent: **COLLIN COUNTY**

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

Description of Item	Purpose & Justification

Total Amount Requested for

gory

lefinition and detailed instructions to complete this

Number of Units	Cost Per Unit	Total
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0

Equipment: **$0**

SUPPLIES Budge

Legal Name of Respondent:

Itemize and describe each supply item and provide an estimated quar
be categorized by each general type (i.e., office, computer, medical, clie

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]

t Category Detail Form (Supplemental)

COLLIN COUNTY

ıtity and cost (i.e. # of boxes & cost/box) if applicable. Provide a justification for each supply item. Costs may nt incentives, educational, etc.)

Purpose & Justification	Total Cost

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

SUPPLIES Bu

Legal Name of Respondent:

Itemize and describe each supply item and provide an estimated quar
be categorized by each general type (i.e., office, computer, medical, clie

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]

dget Category Detail Form (Match)

COLLIN COUNTY

ıtity and cost (i.e. # of boxes & cost/box) if applicable. Provide a justification for each supply item. Costs may nt incentives, educational, etc.)

Purpose & Justification	Total Cost

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

CONTRACTUAL Budget Category Detail Form (Supplier

Legal Name of Respondent: **COLLIN COUNTY**

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the serv
Named." Justification for any contract that de

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)

Total Amount Requested

mental)

vice to be contracted and show contractors as "To Be

# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0

for CONTRACTUAL: $0

CONTRACTUAL Budget Category Detail Form (Mat

Legal Name of Respondent: **COLLIN COUNTY**

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the serv
Named." Justification for any contract that de

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)

Total Amount Requested

ch)

/ice to be contracted and show contractors as "To Be

# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0

for CONTRACTUAL: $0

OTHER COSTS Budg

Legal Name of Respondent:

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]

COLLIN COUNTY

Purpose & Justification	Total Cost

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

OTHER COSTS B

Legal Name of Respondent:

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]

Budget Category Detail Form (Match)

COLLIN COUNTY

Purpose & Justification	Total Cost

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