TB Federal
FY2021 Budget
01.01.2021 - 12.31.2021
Contract HHS000686100011
Grant Award: $114,386

FYI GRANT BUDGET

REVENUE ESTIMATES:

From:

HC-TB FED-ST N/C	GT293Z-2108-600019067-434020	$ 114,386

To:

HC GT---------FUND BALNC	2108-00000-0000-00-00-0000-300251	$ 114,386

f 1/21/2021

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**

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)	Local Funding (Match) (5)	Other Funds (6)
A. Personnel	$74,687	$57,902			$16,785	
B. Fringe Benefits	$31,320	$25,228			$6,092	
C. Travel	$5,498	$5,498			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$9,767	$9,767			$0	
F. Contractual	$4,650	$4,650			$0	
G. Other	$11,341	$11,341			$0	
H. Total Direct Costs	$137,263	$114,386	$0	$0	$22,877	$0
I. Indirect Costs	$0	$0				
J. Total (Sum of H and I)	$137,263	$114,386	$0	$0	$22,877	$0
				Match Percentage	20.00%	

If the Contractor is using Indirect Costs as Match, then enter the amount in Line 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	N	Provides TB case management services as a registered nurse	0.5	License	$6,242.14	12	$37,453
Medical Assistant	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	Travel Costs	
DSHS Annual Training in Austin - 2021	DSHS Annual Training in Austin - 2021 (1 trip x 1000 mi x .58 = $580; 4 days per diem x $41/day x 4 staff = $656; 3 nights lodging x $117/night x 4 staff = $1,404)	Austin	4 employee (4 days)	Mileage	$580
				Airfare	$0
				Meals	$656
				Lodging	$1,404
				Other Costs	$0
				Total	$2,640
				Mileage	
				Airfare	$0
				Meals	
				Lodging	
				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 $2,640

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Local travel for contact investigations, screening, and DOT	1953	$0.580	$1,133		$1,133
Local training travel including a day travel for DFW metroplex	2974	$0.580	$1,725		$1,725
			$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 $2,858

Other / Local Travel Costs: $2,858 Conference / Workshop Travel Costs: $2,640 **Total Travel Costs: $5,498**

Indicate Policy Used: Respondent's Travel Policy [ ] State of Texas Travel Policy [ ]

Revised: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category

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	Number of Units	Cost Per Unit	Total Cost
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**

SUPPLIES Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY

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.)

Description of Item Provide estimated quantity and cost	Purpose & Justification	Total Cost
General Office Supplies-Office Depot; ($333.92/mo X 12 mo = $4,007)	Paper, pens, binders, highlighters, binder clips; other general supplies used for cohort review	$4,007
Reference Materials; ($255/mo X 12 mo = $3,060)	Educational journals/books for TB clinicians and/or education for community health care providers	$3,060
Printed Materials; ($225/mo X 12 mo = $2700)	Mass printing of educational handouts for patients related to TB infection or TB diseases	$2,700
	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 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., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Payments	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL COST
Prima Care	DOT services for TB patients after hours	Needed for TB patients to receive medication after hours and on weekends	Unit	93	$50.00	$4,650
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						$0

Total Amount Requested for CONTRACTUAL: $4,650

OTHER COSTS Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
Language Line ; ($376.75/mo X 12 mo = $4,521)	Translation services for patients to provide education, information about evaluation and treatment, and contact investigations	$4,521
Patient Transportation ; ($416.66/mo X 12 mo = $5,000)	Transporting patients to and from office visits and radiology appointments for public health purposes	$5,000
Monthly AT&T Service --Mifi/Hot Spot ; ($55/month X 12 months X 2 existing mifi devices)	Required for wireless connectivity of tablet used offsite for public health monitoring of patients through videoconferencing	$1,320
Conference Registration ; (3 employees X $166.66 registration fees = $500)	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**

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)	Estimated Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Elva Priest - DOT Worker - E	N	Provides DOT to TB Patients	0.29	NA	$4,823.37	12	$16,785
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$16,785

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 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)

Fringe Benefit Rate %	36.30%
Fringe Benefits Total	$6,092

DEPARTMENT OF STATE HEALTH SERVICES
CONTRACT NO. HHS000686100011
AMENDMENT NO. 1

THE DEPARTMENT OF STATE HEALTH SERVICES (**"System Agency"** or **"DSHS"**) and **COLLIN COUNTY HEALTH CARE SERVICES** (**"Grantee"**), who are collectively referred to herein as the **"Parties"** to that certain grant Contract effective January 1, 2020, and denominated DSHS Contract No. **HHS0006861000011** (**"Contract"**), now want to amend the Contract.

WHEREAS, the Parties desire to renew the term of the Contract for an additional year;

WHEREAS, the Parties desire to add funds for the period beginning January 1, 2021, through December 31, 2021 (hereinafter referred to as **"Fiscal Year 2021"** or **"FY2021"**); and

WHEREAS, the Parties desire to revise the Statement of Work for Fiscal Year 2021.

NOW, THEREFORE, the Parties hereby amend and modify the Contract as follows:

1. **ARTICLE IV** of the Signature Document, **DURATION**, is hereby amended to reflect a revised termination date of December 31, 2021.

2. **ARTICLE V** of the Signature Document, **BUDGET**, is hereby amended to add **$114,386.00** in DSHS funding with the Grantee providing **$22,877.00** in matching funds, for an FY2021 combined total of **$137,263.00**. The total Contract amount will not exceed **$274,526.00.** All expenditures under the Contract will be in accordance with **ATTACHMENT B-1, FY2021 BUDGET.**

3. **ATTACHMENT A, STATEMENT OF WORK**, is hereby deleted and replaced with **ATTACHMENT A-1, REVISED STATEMENT OF WORK.**

4. This Amendment shall be effective on January 1, 2021.

5. Except as amended and modified by this Amendment, all terms and conditions of the Contract shall remain in full force and effect.

6. Any further revisions to the Contract shall be by written agreement of the Parties.

Signature Page Follows

SIGNATURE PAGE FOR AMENDMENT NO. 1
SYSTEM AGENCY CONTRACT NO. HHS000686100011

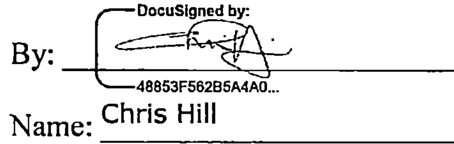
DEPARTMENT OF STATE HEALTH SERVICES

DocuSigned by:
Imelda Garcia
87AFD32AD9D24A9...
Imelda Garcia

Associate Commissioner

Date of Signature: November 24, 2020

COLLIN COUNTY HEALTH CARE SERVICES

By: 

Name: Chris Hill

Title: County Judge

Date of Signature: November 24, 2020

THE FOLLOWING DOCUMENTS ARE ATTACHED AND INCORPORATED AS PART OF THE CONTRACT:

ATTACHMENT A-1	REVISED STATEMENT OF WORK
ATTACHMENT B-1	FY2021 BUDGET
ATTACHMENT G-1	FFATA

ATTACHMENTS FOLLOW

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ATTACHMENT A-1
REVISED STATEMENT OF WORK

I. GRANTEE RESPONSIBILITIES

Grantee will:

A. Comply with the most current version of the Tuberculosis Work Plan located at: http://www.dshs.texas.gov/idcu/disease/tb/policies/.

B. Use federal funds under this Contract to support core TB control front-line activities including but not limited to:
1. Directly observed therapy (DOT);
2. Outpatient services (tuberculin skin testing, chest radiography, medical evaluation, treatment);
3. Contact Investigation;
4. Cohort Review;
5. Surveillance;
6. Reporting;
7. Data analyses;
8. Cluster investigations; and
9. Provider education.

C. Provide a cash match of no less than 20% of the total budget as reflected in the Contract.

D. Provide match at the required percentage or Department of State Health Services (DSHS) may withhold payments, use administrative offsets, or request a refund from Grantee until the required match ratio is met. No federal or other grant funds can be used as part of meeting the match requirement.

E. Ensure no DSHS funds or matching funds are used for:
1. Medication purchases;
2. Inpatient clinical care (hospitalization services);
3. Entertainment;
4. Furniture;
5. Equipment; and
6. Sectarian worship, instruction, or proselytization.

However, food and incentives are allowed using DSHS funds, but are not allowed for matching funds.

F. Not lapse more than 1% of the total funded amount of the Contract.

G. Maintain and adjust spending plan throughout the Contract term to avoid lapsing funds. During the term of this Contract, DSHS reserves the right to decrease funding amounts as a result of the Grantee's budgetary shortfalls and/or due to the Grantee lapsing more than 1% of total funds.

H. Maintain staffing levels to meet required activities of the Contract and to ensure all funds in the personnel category are expended.

I. Use DSHS-designated data systems available for local entry. All collected TB information shall be entered into a designated state TB information system, including all data fields on the Report of Verified Case of Tuberculosis (RVCT), TB340, any laboratory results received locally, and any additional clinical information, according to documented timelines and specifications. Data entered into DSHS data systems will be considered submitted to DSHS.

J. Comply with all applicable federal and state statutes and regulations, policies and guidelines, as revised.

II. PERFORMANCE MEASURES

System Agency will monitor the Grantee's performance of the requirements in Attachment A-1 and compliance with the Contract's terms and conditions.

If Grantee fails to meet any of the performance measures, Grantee will respond to any finding in a written narrative explaining the barriers and the plan to address those barriers. 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.

III. INVOICE AND PAYMENT

Grantee will request payment by preparing an invoice and submitting acceptable supporting documentation for reimbursement of the required services/deliverables. Invoices and supporting documentation shall be submitted to DSHS no later than 30 days after the last day of each month.

A. Grantee will request payments using the State of Texas Purchase Voucher (Form B-13) at http://www.dshs.state.tx.us/grants/forms/b13form.doc. Voucher and any supporting documentation will be mailed or submitted by fax or electronic mail to the address/number below.

Department of State Health Services
Claims Processing Unit, MC 1940
1100 West 49th Street
P.O. Box 149347
Austin, TX 78714-9347
FAX: (512) 458-7442
EMAIL: invoices@dshs.texas.gov & CMSinvoices@dshs.texas.gov

B. Grantee will email the Financial Status Report (FSR-269A) and the Match Certification Form (B-13A) to the following: Invoices@dshs.texas.gov and TBContractReporting@dshs.texas.gov. Grantee must submit final FSR and a reimbursement or final payment request no later than forty-five (45) calendar days following the end of the Contract term.

C. Grantee will be paid on a cost reimbursement basis and in accordance with the Budget in Attachment B-1 of this Contract.

IV. PROGRAMMATIC REPORTING REQUIREMENTS

Report Name	Frequency	Period Begin	Period End	Due Date
FY20 Annual Narrative Report	Annually	Jan. 1, 2020	Dec. 31, 2020	April 1, 2021
FY21 Annual Narrative Report	Annually	Jan. 1, 2021	Dec. 31, 2021	April 1, 2022
Financial Status Report (FSR) & Match Reimbursement/Certification Form (B-13A)	Quarterly	Jan. 1, 2021	Mar. 31, 2021	April 30, 2021
FSR & Form B-13A	Quarterly	April 1, 2021	June 30, 2021	July 31, 2021
FSR & Form B-13A	Quarterly	July 1, 2021	Sept. 30, 2021	Oct. 31, 2021
FSR & Form B-13A	Quarterly	Oct. 1, 2021	Dec. 31, 2021	Feb. 15, 2022

Annual Report Submission Instructions:
Submit program reports to the TB Reporting Mailbox at TBContractReporting@dshs.texas.gov. The DSHS TB Program will provide the form and format for the Annual Narrative Report. The Annual Narrative Report will be a separate report for the Grantee and must not be included with reports for the Region.

ATTACHMENT B-1
FY2021 BUDGET

Grantee: Collin County Health Care Services

Program ID: TB/PC-Federal

Contract Number: HHS000686100011

Budget Categories	DSHS Funds	Cash Match	Category Total
Personnel	$57,902.00	$16,785.00	$74,687.00
Fringe Benefits	$25,228.00	$6,092.00	$31,320.00
Travel	$5,498.00	$0.00	$5,498.00
Equipment	$0.00	$0.00	$0.00
Supplies	$9,767.00	$0.00	$9,767.00
Contractual	$4,650.00	$0.00	$4,650.00
Other	$11,341.00	$0.00	$11,341.00
Total Direct Costs	$114,386.00	$22,877.00	$137,263.00
Indirect Costs	$.00	$0.00	$0.00
Totals:	$114,386.00	$22,877.00	$137,263.00

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Certificate Of Completion

Envelope Id: DCBAF86FA4E94DE6B743B09610E02ACD

Status: Completed

Subject: Amending $274,526; HHS000686100011; Collin County Health Care Services A-1; DSHS/LIDS/TB-FED

Source Envelope:

Document Pages: 12
Certificate Pages: 2
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EnvelopeId Stamping: Enabled
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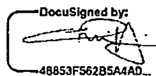
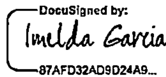
Signatures: 3
Initials: 0

Envelope Originator:
Texas Health and Human Services Commission
1100 W. 49th St.
Austin, TX 78756
PCS_DocuSign@hhsc.state.tx.us
IP Address: 167.137.1.15

Record Tracking

Status	Holder	Location
Status: Original 9/30/2020 2:32:00 PM	Holder: Texas Health and Human Services Commission PCS_DocuSign@hhsc.state.tx.us	Location: DocuSign

Signer Events

Signer Events	Signature	Timestamp
Chris Hill chill@co.collin.tx.us County Judge Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	 Signature Adoption: Uploaded Signature Image Using IP Address: 216.60.33.220	Sent: 9/30/2020 2:40:00 PM Resent: 11/2/2020 9:25:44 AM Viewed: 11/21/2020 8:36:01 AM Signed: 11/24/2020 11:37:04 AM
Imelda Garcia ImeldaM.Garcia@dshs.texas.gov Associate Commissioner Texas Health and Human Services Commission Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	 Signature Adoption: Pre-selected Style Using IP Address: 160.42.85.8	Sent: 11/24/2020 11:37:06 AM Viewed: 11/24/2020 11:57:28 AM Signed: 11/24/2020 11:57:34 AM

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
CMS inbox cmucontracts@dshs.texas.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign		Sent: 9/30/2020 2:40:00 PM

Carbon Copy Events	Status	Timestamp
Lauren Miller Lauren.Miller@dshs.texas.gov CMS Branch Manager Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 9/30/2020 2:39:59 PM Viewed: 10/1/2020 7:39:18 AM
Laura Thomas llthomas@co.collin.tx.us Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 9/30/2020 2:40:00 PM Viewed: 10/26/2020 8:24:16 AM

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	9/30/2020 2:40:00 PM
Certified Delivered	Security Checked	11/24/2020 11:57:28 AM
Signing Complete	Security Checked	11/24/2020 11:57:34 AM
Completed	Security Checked	11/24/2020 11:57:34 AM

Payment Events	Status	Timestamps