TEXAS Health and Human Services

FY2020

COVID-2019 BUDGET AMENDMENT

Applicant Information

Legal Name of 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 # (11 digit + 3 digit mail code)**:**	
DUNS # (9 digits required for subrecipient contracts)**:**	74873449
Fiscal Year-End Date (MM/DD)	09/2020

Type of Entity (Choose one)

City:	☐	Click on appropriate box
County:	☑	
Other Political Subdivision:	☐	
Nonprofit Organization	☐	
Community-Based Organization	☐	
Hospital	☐	
State Controlled Institution of Higher Learning	☐	
Other	☐	
Faith Based (Nonprofit Org)	☐	

Contract Term:

Start Date:	3/15/2020
End Date:	3/15/2022

State-wide or Counties Served

State-wide or County(ies) Served: COLLIN, submitted 4/14/2020, revised 4/17/2020, amended 2/25/21

Amount of Funding Allocated:	$687,462.00
Minimum Unduplicated Clients to be Served	

CONTACT PERSON INFORMATION

Legal Business Name: COLLIN COUNTY

This form provides information about the appropriate contacts in the contractor's organization. If any of the following information changes during the term of the contract, please send written/e-mail notification to the Assigned Contract Manager.

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

B-13 Submitter: JARRAD WINMAN
Direct Phone: 972-548-4732 Ext:
E-mail: JWINMAN@CO.COLLIN.TX.US
Mailing Address (street, city, county, & zip): 2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Program Lead Person: TAYLOR BURTON
Direct Phone: 972-548-4464 Ext:
E-mail: TBURTON@CO.COLLIN.TX.US
Mailing Address (street, city, county, & zip): 825 N. MCDONALD #130, MCKINNEY, TX 75069

Contract Lead Person: SAM GRADER
Direct Phone: 972-548-5503 Ext:
E-mail: SGRADER@CO.COLLIN.TX.US
Mailing Address (street, city, county, & zip): 825 N. MCDONALD #130, MCKINNEY, TX 75069

Contract Authorized Signatory: CHRIS HILL
Direct Phone: 972-548-4623 Ext:
E-mail: CHILL@CO.COLLIN.TX.US
Mailing Address (street, city, county, & zip): 2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Additional Contract Authorized Signatory:
Direct Phone: Ext:
E-mail:
Mailing Address (street, city, county, & zip):

FFATA/Assurances Signatory:
Direct Phone Ext:
E-mail:
Mailing Address (street, city, county, & zip):

BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: COLLIN COUNTY

Budget Categories	TOTAL BUDGET	DSHS Funds Requested (Allocation Amount)
A. Personnel	$386,193	$386,193
B. Fringe Benefits	$126,903	$126,903
C. Travel	$0	$0
D. Equipment	$133,655	$133,655
E. Supplies	$33,808	$33,808
F. Contractual	$0	$0
G. Other	$6,903	$6,903
H. Total Direct Costs	$687,462	$687,462
I. Indirect Cost Rate Amount	$0	$0
J. Total (Sum of H and I)	$687,462	$687,462

Direct Federal Funds	$0.00
Other State Agency Funds	$0.00
Local Funding Sources	$0.00
Other Funds	$0.00

Contract Total	$687,462.00

PERSONNEL Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY

PERSONNEL Name + Functional Title	Position Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)	Estimated Total Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Charles Ryan Russell, PHEP Specialist (D1, A1, 20%; D4, C3, 40%; D5, D1, 20%; D5, D2, 20%)	N	Plans and coordinates open and closed PODS, manages and coordinates MRC, supports grant functions related to COVID-2019, including disease surveillance	100%	NA	$4,050	8	$32,400
Christian Jimenez, PHEP Specialist (D1, A1, 20%; D4, C3, 40%; D5, D1, 20%; D5, D2, 20%)	N	Plans and coordinates open and closed PODS, manages and coordinates MRC, supports grant functions related to COVID-2019, including disease surveillance	100%	NA	$4,293	21	$90,153
Jeff Button, PHEP Specialist (D1, A1, 20%; D4, C3, 40%; D5, D1, 20%; D5, D2, 20%)	N	Plans and coordinates open and closed PODS, manages and coordinates MRC, supports grant functions related to COVID-2019, including disease surveillance	90%	NA	$4,293	20	$77,274
Leon Contreras, PHEP Planner (D1, A3, 20%; D2, 20%; D4, C3, 30%; D5, D1, 30%)	N	Writes and maintains public health response plans for the county such as the Community Intervention Implementation Plan, supports grant functions related to COVID-2019 including disease surveillance	100%	NA	$4,853	8	$38,824
Sowmya Susarla, Functional Analyst (D3, B1, 20%; D5, D1, 30%; D6, E3, 50%)	N	Monitors, updates, and maintains health department's databases/software, identifying areas for improvement, testing updates and new software	100%	NA	$4,853	8	$38,824
Darrell Willis, Public Information Officer (D1, A3, 10%, D3, B1, 30%, D3, B2, 40%; D5, D1, 20%)	N	Coordinates pulic relations activites to provide County employees, citizens, and area media with current information regarding COVID-2019; ensures multiple methods of communication are used for alerting the public and healthcare agencies of risks, status updates, and protective measures	100%	NA	$5,722	19	$108,718
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS			$0
					SalaryWage Total		$386,193

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:	**5.90**		**Fringe Benefit Rate %**	32.86%
			Fringe Benefits Total	$126,903

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	
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

Total for Conference / Workshop Travel $0

Revised: 07-13-2017

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:** $0 **Total Travel Costs:** **$0**

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

Revised: 07-13-2017

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
COVID rapid testing machine (Price, quantity, and type to be determined) (D6, E2)	Rapid testing machine to provide COVID results from individual specimens	5	$2,859	$14,295
Cargo trailer w/ smaller capacity generator (Price, quantity, and type to be determined) (D4, C3)	To deploy POD and other medical materials for COVID/PHEP response activities	2	$13,848	$27,696
Trailer mounted generator-larger capacity, no cargo (Price, quantity, and type to be determined) (D4, C3)	To support critical and emergency operations, COVID and related POD/PHEP response activities in remote areas of the county or at locations lacking necessary power	1	$56,288	$56,288
Mobile refrigerator/freezer (Acutemp AX56L or comparable; price, quantity, and type to be determined) (D4, C3)	Maintain viability of COVID vaccine or medication during transport to a facilty during POD activation	4	$8,844	$35,376
				$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: **$133,655**

SUPPLIES Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY

Itemize and describe each supply item and provide an estimated quantity and cost.

Description of Item Provide estimated quantity and cost	Purpose & Justification	Total Cost
Computer-Tablets X 6 included docking station, keyboard, stylus, mouse, and two monitors; $2433 each (D3, E1, 25%; D5, D1 25%; D6, E1, 25%; D6, E3, 25%)	Computers to be used by health department staff for disease investigations	$14,598
Desk Phones X 8; $330.32 ea (D3, E1, 25%; D5, D1 25%; D6, E1, 25%; D6, E3, 25%)	Desk phones to be used by health department staff to communicate with patients, healthcare providers and others regarding disease investigations	$2,643
Cell Phone-Voice and Data X 6 includes standard mobile phone, case, and car charger; $247.99 ea (D3, E1, 25%; D5, D1 25%; D6, E1, 25%; D6, E3, 25%)	Cell phones to be used by health department staff to communicate with patients, healthcare providers and others regarding disease investigations	$1,488
Cell Phone Service Plan X 3 for 1 year, X 3 for 2 year ; annual cost of voice and data plan $576 ea (D3, E1, 25%; D5, D1 25%; D6, E1, 25%; D6, E3, 25%)	Cell phone voice and data service plan to be used by health department staff using their cell phones to communicate with patients, healthcare providers and others regarding disease investigations	$5,184
Printer-Color-Medium with additional paper tray X 2; $843 each printer, $293 each paper tray (D3, E1, 25%; D5, D1, 25%; D6, E1, 25%; D6, E3, 25%)	Printers to be used by grant staff members to produce disease investigation reports and related documents	$2,272
Scanner - Top Feed X 7; county standard desktop scanner; $870 ea (D3, E1, 25%; D5, D1 25%; D6, E1, 25%; D6, E3, 25%)	Scanners to be used by grant staff members to produce electronic files for retention of disease investigation reports and related documents	$6,090
Personal Protective Equipment-type of product, pricing per item and quantities estimated and will vary (Instant Hand Sanitizer 500 mL $9.29ea X 3) (D1, A2, 33.3%; D4, C3, 33.3%; D5, D3, 33.3%)	Gloves, gowns, masks, respirators, FIT test hood and bitter/sweet solution, and related PPE supplies to support health department clinics, city and county first responder agencies, local health care agencies, and other community stakeholders to preserve existing infrastructure against the spread of disease.	$33
Supplies for Dispensing COVID vaccine or medication--type of product and pricing per item and quantities estimated and will vary (Mobile vaccine cooler batteries $206.75 x 5, Needles $25.36bx X 10, Bandages $68.69case X 1, Alcohol pad $28.40case X 1, Alcohol hand sanitizer $107.70 case X 1) (D1, A2, 25%; D1, A3, 25%; D4, C3, 25%; D5, D3, 25%)	Needles, bandages, gauze, sharps containers, hand sanitizer, alcohol pads, pill bottles, pill counters, data loggers, portable vaccine cooler batteries, and other supplies for health department clinics and local health care agencies to provide COVID vaccinations or medication to essential staff, first responders, and/or the public.	$1,500
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$33,808**

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
NONE						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 07-13-2017

OTHER COSTS Budget Category Detail Form

Legal Name of Respondent: **COLLIN COUNTY**

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
MiFi Device and Service Plan X 6 ; MiFi Device cost $0, annual cost of MiFi service $444 ea (D3, E1, 25%; D5, D1 25%; D6, E1, 25%; D6, E3, 25%)	MiFi devices to be used by health department staff with their cell phone and/or tablet to access the county network, internet, and other software to conduct disease investigations while working remotely	$2,664
Adobe DC software licenses X 6; $72.45 ea (D3, E1, 25%; D5, D1 25%; D6, E1, 25%; D6, E3, 25%)	Computer software to be used by health department staff to edit, combine, and sign electronic .pdf documents used in disease investigation tasks.	$435
Software-EA licenses X 6 includes Microsoft Office Suite; $634 ea to install on tablets (D3, E1, 25%; D5, D1 25%; D6, E1, 25%; D6, E3, 25%)	Computer software to be used by health department staff to communicate by email, produce disease investigation reports, enter and track disease surveillance data	$3,804
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$6,903**

Revised: 07-13-2017

Indirect Cost Rate

Legal Name of Respondent:		**COLLIN COUNTY**
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 (Indirect Costs)**	**RATE:** **BASE:**	
I attest that I have not had an approved indirect cost rate and I am requesting/electing to utilize the de minimis indirect cost rate.		
I elect not to request indirect costs.		

SUPPLEMENTAL FORMS INSTRUCTION

The budget templates (two per budget category) that follow are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template. Applicants that have utilized all the lines on the primary budget template must use the supplemental templates to list detail information for the respective budget category. For example, after all the lines on the primary budget template for Personnel (tab labled Form I - 1 Personnel) have been used, go to the supplemental template labled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labled "Form I - 1b Personnel". The amounts on each supplemental template will automatically total and the total from both templates will automatically be inserted on the last line of the primary budget template.

The supplemental budget templates are:

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

PERSONNEL Budget Category Detail Form (Supplemental)

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
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
			0.00				
					SalaryWage Total		$0

TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: COLLIN COUNTY

Conference / Workshop Travel Costs

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

Total for Conference / Workshop Travel $0

Other / Local Travel Costs

Revised: 07-13-2017

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0

Total for Other / Local Travel $0

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

EQUIPMENT AND CONTROLLED ASSETS Budget Category
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/quote.

Description of Item	Purpose & Justification	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

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

Revised: 07-13-2017

SUPPLIES Budget Category Detail Form (Supplemental)

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 (i.e., office, computer, medical, client incentives, educational, etc.)

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

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

CONTRACTUAL Budget Category Detail Form (Supplemental)

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 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

Total Amount Requested for CONTRACTUAL: $0

Revised: 07-13-2017

OTHER COSTS Budget Category Detail Form (Supplemental)

Legal Name of Respondent: COLLIN COUNTY

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

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

Revised: 07-13-2017