TEXAS Department of State Health Services

FY2022

Immunizations

Applicant Information

Legal Name of Applicant Agency: Collin County

Mailing Address:

Street / PO Box: 825 N. McDonald Street, Suite 130
City: McKinney
Zip: 75069

Payee Name: Collin County

Payee Mailing Address:

Street / PO Box: 825 N. McDonald Street, Suite 130
City: McKinney
Zip: 75069

State of Texas Comptroller Vendor ID # (9 digit + 3 digit mail code)**:** 7873449

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: 9/1/2021
End Date: 8/31/2022

Counties Served

County(ies) Served: COLLIN COUNTY

Amount of Funding Allocated: $354,062.00

CONTACT PERSON INFORMATION

Legal Business Name: 0

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			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-5504	Ext:		
Fax:	972-548-4441			
E-mail:	cblair@co.collin.tx.us			825 N. McDonald #130, McKinney, TX 75069
B-13/FSR Rep:	Jarrad Winman, Grant Accountant/Auditor			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4732	Ext:		
Fax:	972-548-4751			
E-mail:	jwinman@co.collin.tx.us			2300 Bloomdale Dr., #4192, McKinney, TX 75071
IMM/LOCALS Program Leader:	Torres Johnson			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-5549	Ext:		
Fax:	972-548-4441			
E-mail:	tmjohnson@co.collin.tx.us			825 N. McDonald #130, McKinney, TX 75069
IMM/LOCALS Coordinator:	Sam Grader			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-5503	Ext:		
Fax:	972-548-4441			
E-mail:	sgrader@co.collin.tx.us			825 N. McDonald #130, McKinney, TX 75069
Authorized Signatory for **DocuSign**	Chris Hill			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4623	Ext:		
Fax:				
E-mail:	chill@co.collin.tx.us			2300 Bloomdale Dr., #4192, McKinney, TX 75071
Additional Authorized Signatory for **DocuSign** **only if applicable** **(FFATA, Certs, etc)**				
Phone:		Ext:		
Fax:				
E-mail:				
DocuSign "CC" Person	Jarrad Winman			
Phone:	972-548-4732	Ext:		
Fax:	972-548-4751			
E-mail:	jwinman@co.collin.tx.us			
Emergency Contact	Sam Grader			Mailing Address (street, city, county, state, & zip):
Cell Phone:	469-500-5538	Ext:		
Fax:	972-548-4441			
E-mail:	sgrader@co.collin.tx.us			825 N. McDonald #130, McKinney, TX 75069

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 that is locaated 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 Grant Technical Assistance Guide (GTAG) located at the following web site:
https://www.dshs.texas.gov/contracts/gtag.aspx

FORM I: 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 Sources (5)	Other Funds (6)
A. Personnel	$851,835	$252,855	$0	$0	$598,980	$0
B. Fringe Benefits	$266,623	$80,939	$0	$0	$185,684	$0
C. Travel	$8,480	$8,480	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$10,288	$10,288	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$1,500	$1,500	$0	$0	$0	$0
H. Total Direct Costs	$1,138,726	$354,062	$0	$0	$784,664	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$1,138,726	$354,062	$0	$0	$784,664	$0
K. Program Income - Projected Earnings	$67,615	$67,615			$46,592	

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**	**$851,835**	**$851,835**	**Fringe Benefits**	**$266,623**	**$266,623**
	Travel	**$8,480**	**$8,480**	**Equipment**	**$0**	**$0**
	Supplies	**$10,288**	**$10,288**	**Contractual**	**$0**	**$0**
	Other	**$1,500**	**$1,500**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$1,138,726**	**Budget Total**	**$1,138,726**

*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
Immunizations RN-Program Manager	N	Provides program oversight & QA	0.43	RN License	$6,917.23	12	$35,693
Immunization-LVN-E	N	Provides Imm Svcs, Outreach, audits	0.43	LVN License	$3,643.58	12	$18,801
Immunization-LVN-E	N	Provides Imm Svcs, Outreach, audits	0.43	LVN License	$5,018.66	12	$25,896
Immunization-RN-E	N	Provides Imm Svcs, Outreach, audits	0.43	RN License	$6,261.87	12	$32,311
Immunization RN-E	N	Provides Imm Svcs, Outreach, audits	0.43	RN License	$5,740.96	12	$29,623
IPOS/Imm Trac Outreach Spec. E	N	Provides ImmTrac Svcs & Provider Ed.	0.43	NA	$2,855.60	12	$14,735
IPOS/Imm Trac Outreach Spec. E	N	Provides ImmTrac Svcs & VFC Back Up	0.43	NA	$2,671.38	12	$13,784
VFC Specialist.-E	N	Provides Vaccine Inventory, Accountability & Provider QA	0.43	NA	$3,708.22	12	$19,134
Support Tech-E	N	Provides Immunization Cler. Sup	0.43	NA	$2,707.84	12	$13,972
Support Tech-E	N	Provides Immunization Cler. Sup	0.43	NA	$2,707.84	12	$13,972
Health Care Analyst - E	N	Perinatal Hep B & Epidemiology	0.43	NA	$5,061.37	12	$26,117
HC Coordfinator-E	N	Provides Prog. Planning & Evaluation	0.13	NA	$5,651.83	12	$8,817
							$0
					TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS		$0
					SalaryWage Total		$252,855

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

Fringe Benefits: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1,300 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 $26.25 per month, Retirement (salary x 0.08), Supplemental Death Benefit (salary x 0.0025), Unemployment insurance (salary x 0.001). Per life insurance HR, the calculation should be employee salary divided by 1000 and then multiplied by 0.05 (this is for one month). Long-Term Disability $0.0024. Short-Term Disability $2.10 per month. Long-Term Care $30.08 per month.

Fringe Benefit Rate %	32.01%
Fringe Benefits Total	$80,939

Revised: 7/6/2009

FORM I-2: 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	
Immunizaation Branch Mandatory Meeting (fall)	Current immunization program updates, collaboration with other health departments and regions	Austin, TX	3 days, 3 employees	Mileage	$500
				Airfare	
				Meals	$600
				Lodging	$900
				Other Costs	
				Total	$2,000
TVFC Annual Training (January/February)	Current immunization program updates, collaboration with other health departments and regions	Austin, TX or TBD	3 days, 3 employees	Mileage	$500
				Airfare	
				Meals	$600
				Lodging	$900
				Other Costs	
				Total	$2,000
EPI VAC or Epidemiology Training	Current immunization program updates, collaboration with other health departments and regions	Austin, TX or TBD	3 days, 3 employees	Mileage	$500
				Airfare	$800
				Meals	$600
				Lodging	$900
				Other Costs	
				Total	$2,800
				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 $6,800

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Mileage to schools, health care providers, daycares for audits and unannounced visits. Mileage for day travel (Arlington, Dallas, etc..) for training.	3000	$0.560	$1,680		$1,680
			$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 $1,680

Other / Local Travel Costs: $1,680 **Conference / Workshop Travel Costs:** $6,800 **Total Travel Costs:** **$8,480**

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

Revised: 7/6/2009

FORM I-3: EQUIPMENT 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. 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
				$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 Including CONTROLLED ASSETS 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.) 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**
Medical Supplies	Needles 23G 1 IN case @ $96/case X 20 cases, bandaids @ $7.00/box X 100 boxes, gloves @ $26.22/box X 30 boxes, alcohol pads @ $46.12 /box X 2 boxes	$3,500
General Office Supplies	Post it notes @ $21.11/pack X 20 packs, pens for public to fill out forms @ $4.55/box X 60 boxes, highlighters @ $3.45/dozen X 20 dozen, portfolio folders @ $7.61/box X 60 boxes, reams of cardstock @ $8.76/pack X 30 packs, laminating sheets @ $14.93/box X 40 boxes, retractable permanent marker @ 28.39/dozen X 10 dozen, etc..	$2,902
Reference Materials	AAP "Red Book" @$77.00/ea X 7 books, CDC "Pink Book" @ $40/ea X 10 books , "Control of Communicable Diseases" @ $51.79 X 10 books, "Managing Infectious Diseases in Child Care and Schools" @ 62.95 X 10 books, and other reference manual copies for providers for community education	$2,086
Grant Program Supplies	Stickers @ $6.99/roll X 200 rolls; coloring books @ $0.56/book X 200 books, posters featuring vaccine preventable diseases @ $1.50/ea X 200 posters, and other items to support immunization education and outreach activities with patients and stakeholders such as health care providers, schools, hospitals, etc…	$1,800
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0

Revised: 7/6/2009

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
		$0
		$0
		$0
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies:	**$10,288**

FORM I-5: 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., 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**
Postage	Mass mail outs to providers/recruitment list, etc. Monthly $125 x 12	$1,500
		$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: **$1,500**

Revised: 7/6/2009

FORM I - 7 Indirect Costs

Legal Name of Respondent: COLLIN COUNTY

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:**
____	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.	

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SUPPLEMENTAL FORMS INSTRUCTIONS

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:

-Form I-1 Personnel Supplemental

-Form I-2 Travel Supplemental

-Form I-3 Equipment Supplemental

-Form I-4 Supplies Supplemental

-Form I-5 Contractual Supplemental

-Form I-6 Other Supplemental

FORM I-1: PERSONNEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: COLLIN COUNTY

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

Revised: 7/6/2009

FORM I-1: PERSONNEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: COLLIN COUNTY

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

Revised: 7/6/2009

FORM I-2: 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

Revised: 7/6/2009

Other / Local Travel Costs

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**

Revised: 7/6/2009

FORM I-2: 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

Revised: 7/6/2009

Other / Local Travel Costs

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**

Revised: 7/6/2009

FORM I-3: EQUIPMENT 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. 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
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0

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

FORM I-3: EQUIPMENT 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. 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
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0

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

FORM I-4: SUPPLIES including CONTROLLED ASSETS Budget Category Detail Fo

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** 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 Amount Requested for Supplies:

rm (Supplemental)

. Provide a justification for each

Total Cost

$0

FORM I-4: SUPPLIES including CONTROLLED ASSETS Budget Category Detail Fo

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** 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 Amount Requested for Supplies:

ɔrm (Supplemental)

e. Provide a justification for each

Total Cost

$0

FORM I-5: 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. Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e. hourly rate, unit rate, lump sum amount)	TOTAL
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0

Total Amount Requested for CONTRACTUAL: $0

FORM I-5: 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. Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e. hourly rate, unit rate, lump sum amount)	TOTAL
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0

Total Amount Requested for CONTRACTUAL: $0

FORM I-6: OTHER 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: 7/6/2009

FORM I-6: OTHER 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: 7/6/2009

FORM I - 7 Indirect Costs

Legal Name of Respondent: COLLIN COUNTY

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:**
____	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.	

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