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	$56,520	$56,520	$0	$0	$0	$0
B. Fringe Benefits	$16,040	$16,040	$0	$0	$0	$0
C. Travel	$288	$288	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$0	$0	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$0	$0	$0	$0	$0	$0
H. Total Direct Costs	$72,848	$72,848	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$72,848	$72,848	$0	$0	$0	$0
K. Program Income - Projected Earnings	$0	$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**	**$56,520**	**$56,520**	**Fringe Benefits**	**$16,040**	**$16,040**
	Travel	**$288**	**$288**	**Equipment**	**$0**	**$0**
	Supplies	**$0**	**$0**	**Contractual**	**$0**	**$0**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$72,848**	**Budget Total**	**$72,848**

*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

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
Registered Nurse P	Y	Performs COVID-19 vaccine administration, reports vaccine data to the State, requests additional vaccine from State partners, monitors vaccine to ensure vaccine efficacy	100%	N/A	$5,652.00	10	$56,520
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$56,520

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

Fringe Benefits: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1,200 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 %	28.38%
Fringe Benefits Total	$16,040

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	
				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)
Mileage for conducting local vaccine provider vaccine storage and handling education and delivering or picking up COVID-19 vaccines	514	$0.560	$288		$288
			$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 $288

Other / Local Travel Costs: $288 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** **$288**

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

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
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 Including CONTROLLED ASSETS Budget Categor

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.** Pr
Costs may be categorized by each general type (e.g., office, computer, medical, educational, etc.) See attached example for defini
to complete this form.

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**
None	
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	

Total Amount Requested for Supplies:

y Detail Form

ovide a justification for each supply item.
tion of supplies and detailed instructions

Total Cost
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0

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**

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: **Collin County**

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
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 7/6/2009