TEXAS Department of State Health Services

FY2022

Applicant Information

Legal Name of Applicant Agency:	Collin County Health Care Services
Mailing Address:	
Street / PO Box:	825 N. McDonald, Suite 130
City:	McKinney, Texas
Zip:	75069
Payee Name:	
Payee Mailing Address:	
Street / PO Box:	
City:	
Zip:	
State of Texas Comptroller Vendor ID # (11 digit + 3 digit mail code)**:**	756000873
DUNS # (9 digits required for subrecipient contractors)**:**	
Fiscal Year-End Date (MM/DD)	8/31/2022

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

State-wide or Counties Served

State-wide or County(ies) Served:	Collin

Amount of Funding Allocated: $202,300.00

CONTACT PERSON INFORMATION

Legal Business Name: Collin County Health Care Services

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 D Candy Blair
Direct Phone: 972-548-5504 Ext:
E-mail: cblair@co.collin.tx.us
Mailing Address (street, city, county, & zip): 825 N. McDonald, Sute 130, McKinney, Texas 75069

B-13 Submitter: Laura Thomas
Direct Phone: 972-548-4511 Ext:
E-mail: llthomas@co.collin.tx.us
Mailing Address (street, city, county, & zip): 2300 Bloomdale Rd, Suite 3100, McKinney, Texas 75069

Program Lead Person: Candice Akins
Direct Phone: 972-548-5509 Ext:
E-mail: cakins@co.collin.tx.us
Mailing Address (street, city, county, & zip): 825 N. McDonald, Sute 130, McKinney, Texas 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, Sute 130, McKinney, Texas 75069

Contract Authorized Signatory: Judge Chris Hill
Direct Phone: 972-548-4632 Ext:
E-mail: chill@co.collin.tx.us
Mailing Address (street, city, county, & zip): 2300 Boomdale Rd., Suite 4192 McKinney, Texas 75071

Additional Contract Authorized Sig Laura Thomas
Direct Phone: 972-548-4511 Ext:
E-mail: llthomas@co.collin.tx.us
Mailing Address (street, city, county, & zip): 2300 Bloomdale Rd, Suite 3100, McKinney, Texas 75069

FFATA/Assurances Signatory: Judge Chris Hill
Direct Phone 972-548-4632 Ext:
Mailing Address (street, city, county, & zip):

BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: Collin County Health Care Services

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	$156,110	$126,503			$29,607	
B. Fringe Benefits	$57,874	$47,021			$10,853	
C. Travel	$0	$0			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$10,740	$10,740			$0	
F. Contractual	$17,376	$17,376			$0	
G. Other	$660	$660			$0	
H. Total Direct Costs	$242,760	$202,300	$0	$0	$40,460	$0
I. Indirect Costs	$0	$0				
J. Total (Sum of H and I)	$242,760	$202,300	$0	$0	$40,460	$0
				Match Percentage	20.00%	

Revised: 04/14/2014

PERSONNEL Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

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
Chau Nguyen- Public Health Nurse-E	N	Provides Nurse Case Management of TB cases and contacts	0.47	License	$6,413	12	$36,170
Lindsey Thomas-Contact Investigator-E	N	Performs contact investigation duties related to TB cases	0.47	NA	$4,802	12	$27,081
Sovanary Chhuon-Outreach Worker-E	N	Provides directly observed therapy to TB cases and contacts, may assist with contact investigations	0.47	NA	$3,810	12	$21,487
Lus Alonso-Valadez	N	Provides clinical and administrative support to the TB program and its patients; translates for Spanish speaking TB patients during TB services	0.47	Certification	$3,091	12	$17,432
Rachel Davidson	N	Provides Nurse Case Management of TB cases and contacts	0.47	License	$4,314	12	$24,333
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS			$0
					SalaryWage Total		$126,503

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, Retirment (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.

Total Number of FTEs:	2.35		Fringe Benefit Rate %	37.17%
			Fringe Benefits Total	$47,021

TRAVEL Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

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	$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 $0

Revised: 3/25/2014

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
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**

EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent: Collin County Health Care Services

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
				$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: 3/25/2014

SUPPLIES Budget Category Detail Form

Legal Name of Respondent: **Collin County Health Care Services**

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**
Medical Supplies - All supplies used in clinic for TB patients: blood draws for T-Spot testing, masks & sanitizer for TB protocol	Medical supplies used in TB clinic such as: (boxes of blood collection tubes @$55; Masks @$25.00/bx; hand sanitizer btls @ $6.50 ea; butterflies for drawing blood - cases @$60/per case	$2,277
Medical Supplies - all supplies used for TB patients for services and sanitizing. Need sharps to dispose of biohazard waste.	Antimicrobial Liq. Soap bottles @$9 ea.; Caviwipes Tub @$8 ea.; Diamond Grip Gloves Med.bxs @$10 bx.; Diamond Grip Gloves Lge-bxs @$10; Vacutainer Needle Holder bags @ $10 bg; Sharps containers @ $65/case; other medical supplies to treat and evaluate TB patients	$2,783
Medical Supplies - TB supplies necessary for the administration of PPDs and blood draws.	Curity Alcohol preps @$4 bx; Coverlet strip pieces @ $2 bx	$1,514
General Office Supplies	Pens for patients to fill out forms @ $7.19 dz, self stick notes @ $5.82 pk, highlighters @ $4.70 pk, binders for charts @ $7.77 ea, binder tabs @ $3.77 set, padded envelopes @ $39.61 bx	$2,727
Reference Materials	TB reference books/education for providers and TB staff (i.e. AAP "Red Book", Control of Communicable Diseases, etc…)	$1,439
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Revised: 3/25/2014

Total Amount Requested for Supplies:	**$10,740**

CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: **Collin County Health Care Services**

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
Jerry Barnett	Pharmacist	Needed for TB patients meds	Monthly	12	$200.00	$2,400
Oxford Immunotec	T-Spot lab testing	TB blood test	Unit	416	$36.00	$14,976
						$0
						$0
						$0
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for CONTRACTUAL: **$17,376**

OTHER COSTS Budget Category Detail Form

Legal Name of Respondent: **Collin County Health Care Services**

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
Monthly Service-iPhone	Required for the cell phone--$55/month data usage plan x 12 months. Outreach worker needs to report adverse reactions immediately to Physician. Outreach worker needs to be able to find patients home by calling them when they are in the field. Outreach worker needs to be able to call 911 if a medical emergency occurs at the home of a TB patient.	$660
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$660**

Revised: 3/25/2014

Indirect Costs

Legal Name of Respondent:	**Collin County Health Care Services**
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 (Indirect Costs)**	**RATE:**	**EXAMPLE** 8.75%
	BASE:	**EXAMPLE** - Modified total direct, including subgrants and subcontracts up to the first $25,000; excluding equipment, capital equipment, as well as the portion of each subgrant and subcontract in excess of $25,000.00.

***INSTRUCTIONS**: Organizations that have an approved indirect cost rate should complete the section above by marking the box and indicating the rate and base. A copy of the approved rate agreement that will be in effect during the contract term should be submitted with the Budget Templates. If a rate agreement is pending, submit the latest approved agreement.*

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 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 (Supplemental)

Legal Name of Respondent: Collin County Health Care Services

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

PERSONNEL Budget Category Detail Form (Match)

Legal Name of Respondent: Collin County Health Care Services

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
Kasi Jo St.John-Nurse-E	N	Provides Nurse Case Management of TB cases and contacts	0.42	License	$5,874	12	$29,607
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$29,607

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, Retirment (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 %	36.66%
Fringe Benefits Total	$10,853

TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: Collin County Health Care Services

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: 3/25/2014

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: 3/25/2014

TRAVEL Budget Category Detail Form (Match)

Legal Name of Respondent: Collin County Health Care Services

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: 3/25/2014

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: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Supplemental)

Legal Name of Respondent: Collin County Health Care Services

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
				$0

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

Revised: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Match)

Legal Name of Respondent: Collin County Health Care Services

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
				$0

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

SUPPLIES Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County Health Care Services**

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**

Revised: 3/25/2014

SUPPLIES Budget Category Detail Form (Match)

Legal Name of Respondent: **Collin County Health Care Services**

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**

Revised: 3/25/2014

CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County Health Care Services**

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 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)	# 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**

CONTRACTUAL Budget Category Detail Form (Match)

Legal Name of Respondent: **Collin County Health Care Services**

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 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)	# 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**

OTHER COSTS Budget Category Detail Form (Supplemental)

Legal Name of Respondent: Collin County Health Care Services

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: 3/25/2014

OTHER COSTS Budget Category Detail Form (Match)

Legal Name of Respondent: **Collin County Health Care Services**

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: 3/25/2014