TEXAS Department of State Health Services

FY2022

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)**:**	74873449

Type of Entity (Choose one)

City:	☐	Click on appropriate box
County:	☑	
Other Political Subdivision:	☐	

Project Period

Start Date:	1/1/2022
End Date:	12/31/2022

Counties Served

County(ies) Served:	COLLIN

Amount of Funding Allocated: **$114,386.00**

CONTACT PERSON INFORMATION

Legal Business Name: COLLIN COUNTY

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:		825 N. MCDONALD #130, MCKINNEY, TX 75069
Fax:	972-548-4441			
E-mail:	CBLAIR@CO.COLLIN.TX.US			
B-13/FSR Rep:	LAURA THOMAS			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4511	Ext:		2300 BLOOMDALE RD, SUITE 3100, MCKINNEY, TX 75071
Fax:	972-548-4751			
E-mail:	LLTHOMAS@CO.COLLIN.TX.US			
PHEP (HAZARDS) Program Leader:				Mailing Address (street, city, county, state, & zip):
Phone:		Ext:		
Fax:				
E-mail:				
SNS (CRI) Coordinator:				Mailing Address (street, city, county, state, & zip):
Phone:		Ext:		
Fax:				
E-mail:				
Authorized Signatory for **DocuSign**	CHRIS HILL			Mailing Address (street, city, county, state, & zip):
Phone:		Ext:		2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069
Fax:				
E-mail:	CHILL@CO.COLLIN.TX.US			
Additional Authorized Signatory for **DocuSign only if applicable (FFATA, Certs, etc)**				
Phone:		Ext:		
Fax:				
E-mail:				
DocuSign "CC" Person	LAURA THOMAS			
Phone:	972-548-4511	Ext:		
Fax:	972-548-4751			
E-mail:	LLTHOMAS@CO.COLLIN.TX.US			
Emergency Contact	Samuel Grader			Mailing Address (street, city, county, state, & zip):
Cell Phone:	469-500-5538	Ext:		825 N. MCDONALD #130, MCKINNEY, TX 75069
Fax:	972-548-4441			
E-mail:	SGRADER@CO.COLLIN.TX.US			

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	$75,690	$58,906			$16,784	
B. Fringe Benefits	$31,758	$25,665			$6,093	
C. Travel	$5,374	$5,374			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$8,944	$8,944			$0	
F. Contractual	$4,150	$4,150			$0	
G. Other	$11,347	$11,347			$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.

Revised: 04/14/2014

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 - Dawn West-E	N	Provides TB case management services as a registered nurse	0.49	License	$6,525.00	12	$38,367
Medical Assistant - Cynthia Leung-E	N	Serves as TB case registrar, performing TB data collection and reporting duties	0.49	N/A	$3,493.00	12	$20,539
							$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		$58,906

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:	**0.98**		**Fringe Benefit Rate %**	43.57%
			Fringe Benefits Total	$25,665

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 - 2022	DSHS Annual Training in Austin - 2022: Mileage (1 trip x 1000 mi x .56 = $560; Lodging: 4 Nights x $96/Night x 4 Persons x 1 Trip = $1536; Per Diem: 4 Days @$46/day x 4 persons x 1 Trip = $736 Travel Fees: 4 persons @ $12.00 x 1 Trip = $48	Austin	4 employee (4 days)	Mileage	$560
				Airfare	$0
				Meals	$736
				Lodging	$1,536
				Other Costs	$48
				Total	$2,880
				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

Revised: 3/25/2014

Total for Conference / Workshop Travel $2,880

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 (80 trips x 2 people x 12.21 mile r/t @.56/mile = 1094.00)	1953	$0.560	$1,094		$1,094
Local training travel including a day travel for DFW metroplex (100 trips x 2 people x 12.5 mile r/t @.56/mile = 1400.00)	2500	$0.560	$1,400		$1,400
			$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 $2,494

Other / Local Travel Costs: $2,494 **Conference / Workshop Travel Costs:** $2,880 **Total Travel Costs:** **$5,374**

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

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
				$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**

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; (303.67 x12 months = 3644.00)	Paper, pens, binders, highlighters, binder clips; other general supplies used for cohort review	$3,644
Reference Materials (233.33x 12 months=2800.00	Educational journals/books for TB clinicians and/or education for community health care providers	$2,800
Printed Materials (208.33x 12 months = 2500.00)	Mass printing of educational handouts for patients related to TB infection or TB diseases	$2,500
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$8,944**

Revised: 3/25/2014

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	83	$50.00	$4,150
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
				TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS		$0

Total Amount Requested for CONTRACTUAL: **$4,150**

Revised: 3/25/2014

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 ($377.25 x 12 Months = $4527.00)	Translation services for patients to provide education, information about evaluation and treatment, and contact investigations	$4,527
Patient Transportation ($416.66/Mo x 12 mo = $5000.00)	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: **$11,347**

Revised: 3/25/2014

Indirect Costs

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 (Form I - 7 Indirect)**

RATE:
BASE:

Applies only to governmental entities . The respondent's current central service cost rate **or** indirect cost rate. **Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.**

Note: Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

RATE:
TYPE:
BASE:

A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date.

GO TO PAGE 2 (below)

Page 2, FORM I - 7 Indirect Costs

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**

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

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
			0.00				
					SalaryWage Total		$0

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	0.28	NA	$5,019.00	12	$16,784
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$16,784

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	$6,093

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: 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

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

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**

Revised: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Match)

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
				$0

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

Revised: 3/25/2014

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**

SUPPLIES Budget Category Detail Form (Match)

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**

Revised: 3/25/2014

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 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

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

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

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