

## **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 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 DSHS Contractors Financial Procedures Manual located at the following web site:  
<http://www.dshs.state.tx.us/contracts/>

## FORM I: 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 Sources (5)	Other Funds (6)
A. Personnel	\$218,544	\$218,544	\$0	\$0	\$0	\$0
B. Fringe Benefits	\$88,379	\$88,379	\$0	\$0	\$0	\$0
C. Travel	\$8,586	\$8,586	\$0	\$0	\$0	\$0
D. Equipment	\$0	\$0	\$0	\$0	\$0	\$0
E. Supplies	\$125,421	\$125,421	\$0		\$0	\$0
F. Contractual	\$0	\$0	\$0	\$0	\$0	\$0
G. Other	\$28,615	\$28,615	\$0	\$0	\$0	\$0
H. Total Direct Costs	\$469,545	\$469,545	\$0	\$0	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0		\$0	\$0
J. Total (Sum of H and I)	\$469,545	\$469,545	\$0	\$0	\$0	\$0
K. Program Income - Projected Earnings	\$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 Category	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	Personnel	\$218,544	\$218,544	Fringe Benefits	\$88,379	\$88,379
	Travel	\$8,586	\$8,586	Equipment	\$0	\$0
	Supplies	\$125,421	\$125,421	Contractual	\$0	\$0
	Other	\$28,615	\$28,615	Indirect Costs	\$0	\$0

<b>TOTAL FOR:</b>	<b>Distribution Totals</b>	<b>\$469,545</b>	<b>Budget Total</b>	<b>\$469,545</b>
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\*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

<b>PERSONNEL</b>							
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
Disease Intervention Specialist	Y	Conducts Field Investigations to provide disease intervention and field rapid tests for HIV and syphilis, partner elicitation/notification	1.00	NA	\$5,277.00	8	\$42,216
Disease Intervention Specialist	Y	Conducts Field Investigations to provide disease intervention and field rapid tests for HIV and syphilis, partner elicitation/notification	1.00	NA	\$5,277.00	8	\$42,216
Epidemiologist	Y	Receives all lab reports related to syphilis and other reportable STDs. Ensures their data-entry into various systems; is responsible for initiating field records to DIS related to syphilis. Provides provider education regarding CDC treatment guidelines	1.00	NA	\$5,277.00	8	\$42,216
Epidemiologist	Y	Receives all lab reports related to syphilis and other reportable STDs. Ensures data-entry into various systems; responsible for initiating field records to DIS related to syphilis; provides provider education regarding CDC treatment guidelines	1.00	NA	\$5,277.00	8	\$42,216
Project Manager	Y	Coordinates DIS grant deliverables & activities; supports grant functions related to DIS	1.00	NA	\$6,210.00	8	\$49,680
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0

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									\$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS									\$0

SalaryWage Total	\$218,544
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<b>FRINGE BENEFITS</b>
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Itemize the elements of fringe benefits in the space below:

a. 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 %	40.44%
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	Fringe Benefits Total	\$88,379
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## FORM I-2: 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:	Travel Costs	
			Days/Employees		
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	<b>\$0</b>
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	<b>\$0</b>
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	<b>\$0</b>
				Mileage	\$0
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	<b>\$0</b>
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0

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)
Reimbursable mileage for staff to conduct local travel for for DIS grant related activities.	13333	\$0.560	\$7,466		\$7,466
Local training travel including day travel throughout DFW metroplex.	2000	\$0.560	\$1,120		\$1,120
			\$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

\$8,586

Other / Local Travel Costs: \$8,586

Conference / Workshop Travel Costs: \$0

Total Travel Costs: \$8,586

Indicate Policy Used:

Respondent's Travel Policy

State of Texas Travel Policy

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**FORM I-3: 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. See attached example for equipment definition and detailed instructions to complete this form.

[illegible]

**Total Amount Requested for Equipment:**

**\$0**

## FORM I-4: 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.) See attached example for definition of supplies and detailed instructions to complete this form.

Description of Item <small>[If applicable, provide estimated quantity and cost (i.e. # of boxes &amp; cost/box)]</small>	Purpose & Justification	Total Cost
Computer-Tablets x5 including docking station, key board, mouse, and two monitors; (\$2750 each/unit x 5 = \$13750)	Computers to used by health department staff for public health operations.	\$13,750
Desk Phones x 5 (\$308/unit x5 = \$1540)	Desk phones to be used by health department staff to communicate with stakeholders, providers and others regarding public health activities	\$1,540
Printer-Color-Medium x2, with x2 additional paper tray (\$928/unit x 2 printer); (\$230 x 2 paper tray)	Printers to be used by staff to produce grant related documents.	\$2,316
Office Supplies	Clipboards, paper, writing utensils, labels, folders, binders, etc...to produce reports, documentation, and support grant functions. (Individual supply items will not exceed \$499.00)	\$3,000
Scanner - Top Feed x5; county standard desktop scanner; (\$934/unit x 5)	Standard desktop scanner for staff assisting in DIS activities to scan and deliver electronic reports and documentation.	\$4,670
Medical Supplies; Estimated \$2083.33 per month DIS medical supplies (\$2083.33 x 8 months)	Supplies used for DIS field testing and patient services, sanitation, biohazard waste, and supplies necessary for administration of blood draws such as alcohol wipes, bandages, sharps containers, blood collection tubes, hand sanitizer bottles, gloves, coverlet strip pieces, etc.	\$16,667
Test kits (e.g., syphilis, HIV rapid); Estimate about 350 kits per month at an average of \$10/kit. (\$10/unit x 350/month x 8 months = \$28000)	For specimen collection conducted by DIS when conducting public health follow-up to facilitate case finding and partner services activities.	\$28,000
Vehicle Rentals; This is a monthly rental expense of \$1500 per month, per vehicle (\$1500 x 2 x 8 = \$24000)	Renting of two vehicles to be used by staff to conduct field investigation activities;	\$24,000



Fuel supply for vehicles (\$300/month x 2 x 8 = \$4800)	Fuel supply for vehicles that will support the critical functions of grant and staff activities.	\$4,800
Cell Phones (\$300/unit x 5 = \$1500)	Mobile Cell Devices for staff to communicate with clients in the field. Includes phone, case, and car charger (\$300/unit x 5)	\$1,500
Specimen Collection Laboratory Fees (\$350/unit x 50 lab submissions = \$17,500.00)	Specimen collection fees for STD program to cover lab fees for full panel STD infections to include chlamydia, gonorrhea, trichomoniasis, cytomegalovirus, hepatitis, herpes, HIV, and syphilis.	\$17,500
Transport Coolers for DIS Program; (\$1000/unit x 4 = \$4000)	Medical-grade coolers and freezers for transporting blood products and specimen for field investigations and emergency events.	\$4,000
Medical Waste Pickup Service Fees; Estimated \$459.75/month service fee x 8 months	Waste disposal service fees for the DIS program's medical/biohazard waste.	\$3,678
		\$0
		\$0
		\$0
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

**Total Amount Requested for Supplies:**

**\$125,421**

## FORM I-5: 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., 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 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
Adobe DC Software Licenses (\$425/unit x 5)	Computer software to be used by health department staff to edit, combine, and sign electronic .pdf documents used in stakeholder outreach tasks.	\$2,125
Software-EA Licenses including Microsoft Office Suite (\$762/unit x 5)	Computer software to be used by health department staff to communicate by email, produce disease reports, enter and track disease surveillance data	\$3,810
Uniforms for STD/HIV Program Staff (\$400/unit x 6 FTEs = \$2400)	Uniforms for program staff that will be involved in daily HIV/STD program activities to ensure staff & patient safety.	\$2,400
Printing and Communication Materials	Printing for additional grant related activities, events and public education or other outreach brochures, flyers, postcards, coloring books, posters and other materials to educate the public; printing of employee business cards, as needed.	\$5,000
Postage	Postage for outreach materials, mailings, and communications with stakeholders.	\$2,000
5x Computer Data Service Plan; (\$480/unit annually x 5)	Data cards (with data plan) for computer devices for DIS grant field activities to access the county network, internet, and other software while working remotely.	\$2,400
5x Cell Phone Service Plans (\$576 x 5 = \$2880)	Voice and Data Plans for cell phones for communication with clients in the field while conducting public health follow-up activities.	\$2,880
Certifications and Staff Training	Staff to be trained on HIPAA (\$30/unit x 5 FTEs = \$150), Blood Borne Pathogens (\$30/unit x 5 FTEs = \$150), Sexual Harrassment (\$30/unit x 5 FTEs = \$150), Saf T-Pak (\$110/unit x 5 FTEs = \$550), Phlebotomy (\$1000/unit x 2 FTEs = \$2000), and other DIS trainings.	\$8,000
		\$0
		\$0

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		\$0
		\$0
		\$0
		\$0
		\$0
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

**\$28,615**

## FORM I - 7 Indirect Costs

Legal Name of Respondent:

Collin County Health Care Services

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 based on a rate proposal prepared in accordance with OMB Circular A-87. **Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.**

**RATE:**

**TYPE:**

**BASE:**

\_\_\_\_\_ **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.

\_\_\_\_\_ 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. The CFPM is available on the following internet web link: <http://www.dshs.state.tx.us/contracts/>

**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 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 labeled Form I - 1 Personnel) have been used, go to the supplemental template labeled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labeled "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 Health Care Services

<b>PERSONNEL</b>							
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
						<b>SalaryWage Total</b>	<b>\$0</b>



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

Legal Name of Respondent:

Collin County Health Care Services

<b>PERSONNEL</b>							
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
						<b>SalaryWage Total</b>	<b>\$0</b>

## FORM I-2: 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	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0

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)
			\$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**

## FORM I-2: 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	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0

Total for Conference / Workshop Travel

\$0

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**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**



**FORM I-3: 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.

[illegible]

**Total Amount Requested for Equipment:**

**\$0**

## FORM I-4: 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



## FORM I-4: 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

## FORM I-5: 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 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
						\$0

Total Amount Requested for CONTRACTUAL:

**\$0**

## FORM I-5: 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 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
						\$0

Total Amount Requested for CONTRACTUAL:

**\$0**

## FORM I-6: OTHER 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

## FORM I-6: OTHER 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