



FY2023

Contract Type: CPS/CRI

**Applicant Information**

**Legal Name of Applicant Agency:**  
**Mailing Address:**

COLLIN COUNTY

Street / PO Box: 825 N. MCDONALD ST #130  
City: MCKINNEY, TX  
Zip: 75069

**Payee Name:**

COLLIN COUNTY

**Payee Mailing Address:**

Street / PO Box: 825 N. MCDONALD ST #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):

**Texas Payee ID No.**

**Federal Employer Identification Number**

74873449

17560008736

75-6000873

**Type of Entity (Choose one)**

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

**Project Period**

Start Date: 7/1/2022  
End Date: 6/30/2023

**Counties Served**

County(ies) Served:

COLLIN COUNTY

**Amount of Funding Allocated:**

\$133,431.00

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
Phone: 972-548-5504
Fax:
E-mail: cblair@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD ST #130, MCKINNEY, TX 75069

B-13/FSR Rep: Jarrad Winman
Phone: 972-548-4732
Fax:
E-mail: jwinman@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

PHEP (HAZARDS) Program Leader: Meredith Nurge
Phone: 972-548-4708
Fax:
E-mail: mnurge@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD ST #130, MCKINNEY, TX 75069

SNS (CRI) Coordinator: Amy Davis
Phone: 972-548-4473
Fax:
E-mail: aldavis@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD ST #130, MCKINNEY, TX 75069

Authorized Signatory for DocuSign Chris Hill
Phone: 972-548-4623
Fax:
E-mail: chill@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Additional Authorized Signatory for DocuSign only if applicable (FFATA, Certs, etc) Jarrad Winman
Phone: 972-548-4732
Fax:
E-mail: jwinman@co.collin.tx.us

DocuSign "CC" Person Eric Dickey
Phone: 972-548-5696
Fax:
E-mail: edickey@co.collin.tx.us

Emergency Contact Taylor Burton
Cell Phone: 214-973-2023
Fax:
E-mail: tburton@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD ST #130, MCKINNEY, TX 75069

## 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	\$88,310	\$84,657			\$3,653	
B. Fringe Benefits	\$37,488	\$36,047			\$1,441	
C. Travel	\$5,267	\$5,267			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$2,980	\$2,980			\$0	
F. Contractual	\$0	\$0			\$0	
G. Other	\$12,730	\$4,480			\$8,250	
H. Total Direct Costs	\$146,775	\$133,431	\$0	\$0	\$13,344	\$0
I. Indirect Costs	\$0	\$0				
J. Total (Sum of H and I)	\$146,775	\$133,431	\$0	\$0	\$13,344	\$0
				Match Percentage	<b>10.00%</b>	

If the Contractor is using Indirect Costs as Match, then enter the amount in Line 16, Column H.

**PERSONNEL Budget Category Detail Form**

Legal Name of Respondent:

COLLIN COUNTY

<b>PERSONNEL</b>								
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	
Aubrey Saylor, PHEP Planner	N	Performs PHEP activities to include supporting planning needs, partnering with stakeholders, and other grant functions	0.25	NA	\$6,071	12	\$18,213	
Amy Davis, PHEP Planner	N	Performs PHEP activities to include supporting planning needs, partnering with stakeholders, and other grant functions	1.00	NA	\$5,537	12	\$66,444	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
<b>TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS</b>								\$0
						<b>SalaryWage Total</b>	<b>\$84,657</b>	

<b>FRINGE BENEFITS</b>		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), 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.			
<b>Total Number of FTEs:</b>	1.25	<b>Fringe Benefit Rate %</b>	42.58%
		<b>Fringe Benefits Total</b>	<b>\$36,047</b>

## 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:	Travel Costs	
			Days & Employees		
TALON Conference	Conference for public health and emergency preparedness professionals	TBD	5 days/1 employee	Mileage	\$400
				Airfare	
				Meals	\$300
				Lodging	\$1,500
				Other Costs	\$300
				<b>Total</b>	<b>\$2,500</b>
NACCHO Conference	Conference for public health and emergency preparedness professionals	TBD	7 days/1 employee	Mileage	\$50
				Airfare	\$700
				Meals	\$400
				Lodging	\$1,200
				Other Costs	\$300
				<b>Total</b>	<b>\$2,650</b>
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	<b>\$0</b>
				Mileage	\$0
				Airfare	\$0
				Meals	\$0
				Lodging	\$0
				Other Costs	\$0
				<b>Total</b>	<b>\$0</b>
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0

**Total for Conference / Workshop Travel**

**\$5,150**

**Other / Local Travel Costs**

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Out of office meetings, seminars, exercises, training, including day travel within DFW metroplex. Will be utilized by all PHEP funded staff.	200	\$0.585	\$117		\$117
			\$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** \$117

Other / Local Travel Costs: \$117

Conference / Workshop Travel Costs: \$5,150

**Total Travel Costs:** \$5,267

Indicate Policy Used:

Respondent's Travel Policy Yes

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

Total Amount Requested for Equipment:

\$0

## 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 <small>Provide estimated quantity and cost</small>	Purpose & Justification	Total Cost
Office Supplies	Clipboards, paper, writing utensils, labels, folders, binders, etc...to produce reports, documentation, and support grant functions.	\$650
Reflective Safety Vests/Deployment Supplies	<p>Designated reflective safety vests for Medical Reserve Corps members, to be worn at POD sites (drive-thru, outdoor or indoor location), real world events, or exercises and drills. Reflective safety vests will identify roles and specific skillset of volunteers at POD site locations or MRC events, as well as distinguish volunteers from public health emergency preparedness staff. The reflective safety vests will help identify volunteers stationed in various sections at a POD (i.e. Safety, Logistics, Screening, etc.), as well as distinguish our staff and volunteers from other jurisdictions. The reflective safety vests are essential for safety and traffic control at PODs and MRC events. Approximately \$20 each. Specifications: ANSI compliance preferred, breathable material with reflective tape.</p> <p>Deployment supplies are for the MRC members to be prepared for activation to an incident, event or POD site; these supplies include preparedness items and the necessary supplies to sustain activities (i.e., preparedness supplies, "go bag" supplies, blankets, first aid kits, totes, portable chargers, etc....)</p>	\$650



<p>POD and Dispensing Supplies</p>	<p>Various supplies for deployable POD kits. These include additional POD signage inside the POD, external signage and drive-thru items (such as cones, safety lights, small barriers, and stanchions), replacement or existing expired POD supplies (such as hand sanitizer, hand held radios, batteries, bandages, scales, masks, PPE, storage containers and bags, training assets for drills, etc...), administrative supplies for drive-thru PODs (such as enclosed clipboards), and POD inventory supplies (such as inventory marking tools and supplies). Gloves, masks, crowd control posts, signs, etc., as needed to support various deliverables, including Mass Prophylaxis operations and dispensing models other than open PODs. Also includes alpha or first responder POD planning not covered by POD supplies. Office-type supplies, specific quantities or items are not finalized at this time.</p>	<p style="text-align: right;">\$1,180</p>
<p>MRC Supplies</p>	<p>Deployment supplies are for the MRC members to be prepared for activation to an incident, event or POD site; these supplies include preparedness items and the necessary supplies to sustain activities (i.e. preparedness supplies, "go bag" supplies, blankets, first aid kits, totes, portable chargers, etc....)</p>	<p style="text-align: right;">\$500</p>
<p>TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS</p>		<p>\$0</p>

**Total Amount Requested for Supplies:**

**\$2,980**

## 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
None						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL: **\$0**

## OTHER COSTS Budget Category Detail Form

Legal Name of Respondent:

COLLIN COUNTY

Description of Item <small>Include quantity and cost/quantity</small>	Purpose & Justification	Total Cost
ATT Wireless Cell Phone Service Plans	Cell phone voice and data service plan to be used by grant staff using their cell phones to communicate with stakeholders, providers, and others regarding public health activities. (\$55/month x 2 staff x 12 months = \$1320)	\$1,320
MiFi Device Service Plans	MiFi device service plans to be used by staff with their cell phone and/or laptop to access the county network, internet, and other software for program activities (\$40 x 12 months x 2 employees = \$960)	\$960
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 about SNS and mass prophylaxis; printing of employee business cards, as needed.	\$650
Conference/Workshop Registration Fees	Registration fees for: registration for NACCHO Preparedness Summit \$800 X 1, TALON Conference \$100 X 1, or other conference/workshop fees relevant to the program	\$900
Online Training	Bloodborne pathogens, HIPAA and Confidentiality, Sexual Harrassment, Saf-T Pak, and Cultural Competancy online training for PHEP staff and Medical Reserve Corps members. The bloodborne pathogens training is intended to educate about bloodborne diseases and proper PPE which during a large scale disaster or POD activation the MRC may be rendering medical care. HIPAA and confidentiality training to assure compliance with Federal HIPAA regulations,PHEP staff and the MRC will be involved with patient data through screening forms at POD sites and at flu clinics. Modules will be purchased as needed.	\$650

	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	\$0

**Total Amount Requested for Other:**

<b>\$4,480</b>
----------------

## 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	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
Name + Functional Title							
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
			0.00			<b>SalaryWage Total</b>	<b>\$0</b>

## PERSONNEL Budget Category Detail Form (Match)

Legal Name of Respondent:

COLLIN COUNTY

PERSONNEL	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
MATCH - Jarrad Winman, Grant Accountant	N	Completes FSRs and maintains fiscal auditing documentation	0.05	NA	\$6,089	12	\$3,653
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
<b>SalaryWage Total</b>							<b>\$3,653</b>

FRINGE BENEFITS	Itemize the elements of fringe benefits in the space below:		
	<p>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.</p>		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>Fringe Benefit Rate %</b></td> <td style="text-align: right;"><b>39.44%</b></td> </tr> </table>	<b>Fringe Benefit Rate %</b>	<b>39.44%</b>
<b>Fringe Benefit Rate %</b>	<b>39.44%</b>		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>Fringe Benefits Total</b></td> <td style="text-align: right;"><b>\$1,441</b></td> </tr> </table>	<b>Fringe Benefits Total</b>	<b>\$1,441</b>
<b>Fringe Benefits Total</b>	<b>\$1,441</b>		

## 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	
				<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
			\$0		\$0

**Total for Other / Local Travel**

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

**Total Travel Costs:**

## 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	
				<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**

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

**Total Travel Costs:**

**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
				\$0
				\$0
				\$0
				\$0

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

## 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
				\$0
				\$0
				\$0
				\$0
				\$0

Total Amount Requested for Equipment:

<b>\$0</b>
------------



## SUPPLIES Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

<u>COLLIN COUNTY</u>
----------------------

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 <small>[If applicable, provide estimated quantity and cost (i.e. # of boxes &amp; cost/box)]</small>	Purpose & Justification	Total Cost

Total Amount Requested for Supplies:

<b>\$0</b>
------------

### 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 <small>[If applicable, provide estimated quantity and cost (i.e. # of boxes &amp; cost/box)]</small>	Purpose & Justification	Total Cost

Total Amount Requested for Supplies:

**\$0**

## 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
						\$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 <small>[If applicable, include quantity and cost/quantity (i.e. # of units &amp; cost/unit)]</small>	Purpose & Justification	Total Cost

Total Amount Requested for Other:

\$0

### OTHER COSTS Budget Category Detail Form (Match)

Legal Name of Respondent:

COLLIN COUNTY

Description of Item <small>[If applicable, include quantity and cost/quantity (i.e. # of units &amp; cost/unit)]</small>	Purpose & Justification	Total Cost
MATCH - Volunteer Activities	MRC volunteer training and events participation (26.43/hour - calculated from Independent Sector for 312 hours of service)	\$8,250

Total Amount Requested for Other:

<b>\$8,250</b>
----------------