



FY2023

Contract Type: CPS/Hazards

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:

\$562,786.00

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	\$421,662	\$376,718			\$44,944	
B. Fringe Benefits	\$168,991	\$157,656			\$11,335	
C. Travel	\$9,526	\$9,526			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$4,662	\$4,662			\$0	
F. Contractual	\$0	\$0			\$0	
G. Other	\$14,224	\$14,224			\$0	
H. Total Direct Costs	\$619,065	\$562,786	\$0	\$0	\$56,279	\$0
I. Indirect Costs	\$0	\$0				
J. Total (Sum of H and I)	\$619,065	\$562,786	\$0	\$0	\$56,279	\$0
				Match Percentage	10.00%	

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

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
Meredith Nurge, PHEP Coordinator	N	Coordinates PHEP grant deliverables & activities	1.00	NA	\$6,163	12	\$73,956
Jerry Joseph, PHEP Planner	N	Performs PHEP activities to include supporting planning needs, partnering with stakeholders, and other grant functions	1.00	NA	\$5,298	12	\$63,576
Mandie Sosa, Administrative Secretary	N	Provides administrative support for the PHEP team	0.50	NA	\$4,764	12	\$28,584
Aubrey Saylor, PHEP Planner	N	Performs PHEP activities to include supporting planning needs, partnering with stakeholders, and other grant functions	0.75	NA	\$6,071	12	\$54,639
Jawaid Asghar, Chief Epidemiologist	N	Coordinates epidemiology services and disease investigation	0.40	NA	\$9,101	12	\$43,685
Susana Ramos, Health Care Analyst	N	Performs disease & contact investigations, influenza surveillance, PEP distribution	1.00	NA	\$5,692	12	\$68,304
Vada Caffery, Administrative Secretary	N	Provides administrative support for the Epidemiology team	0.75	NA	\$4,886	12	\$43,974
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS							\$0
						SalaryWage Total	\$376,718

FRINGE BENEFITS		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.			
Total Number of FTEs:	5.40	Fringe Benefit Rate %	41.85%
		Fringe Benefits Total	\$157,656

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		
Quarterly PHEP Contractor Meeting (four meetings)	Required contractor meeting conducted by DSHS	Austin, TX	4 meetings / 2 days / 1 employee	Mileage	\$1,200
				Airfare	\$0
				Meals	\$350
				Lodging	\$1,440
				Other Costs	\$100
				Total	\$3,090
Preparedness Coalition Symposium	Conference for public health and emergency preparedness professionals	TBD	6 days/2 employee	Mileage	\$400
				Airfare	
				Meals	\$300
				Lodging	\$750
				Other Costs	\$150
				Total	\$1,600
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
				Total	\$2,650
Texas Emergency Management Conference	Conference for public health and emergency preparedness professionals	TBD	6 days/2 employee	Mileage	\$400
				Airfare	\$0
				Meals	\$300
				Lodging	\$750
				Other Costs	\$150
				Total	\$1,600
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0

Total for Conference / Workshop Travel

\$8,940

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.	500	\$0.585	\$293		\$293
Short seminars, conferences, meetings within state of Texas. Will be utilized by all PHEP funded staff.	500	\$0.585	\$293		\$293
			\$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 \$586

Other / Local Travel Costs: \$586

Conference / Workshop Travel Costs: \$8,940

Total Travel Costs: \$9,526

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
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.	\$500
POD Supplies	Various supplies for deployable POD kits. These include additional POD signage inside the POD, external signage and drive-thru items (such as cones, stanchions, safety lights, and small barriers), 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).	\$4,162

	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	\$0
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Total Amount Requested for Supplies:

\$4,662

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
						\$0
						\$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 4 staff x 12 months = \$2640)	\$2,640
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
Software for data collection system interfaces, data processing, and data visualizations - License type and quantity will vary	Software examples may include licenses and maintenance fees for Laserfiche, Jotform, DocuSign, Tableau, ArcGIS, SQL, or other systems.	\$4,274
Conference/Workshop Registration Fees	Registration fees for: registration for NACCHO Preparedness Summit \$800 X 1, Preparedness Coalition Symposium \$300 x1, Texas Emergency Management Conference \$200 X 1, or other TBD local area conference/workshop fees relevant to the program	\$1,300
Online Training	Bloodborne Pathogens, HIPAA and Confidentiality 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 50 modules @ \$20.00 = \$1000. 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.	\$1,000

Subscriptions/References	Reference and subscription materials regarding public health for news and studies for overall awareness of current trends and issues (i.e. Epidemiology of Vaccine Preventable Diseases "Pink Book", AAP "Red Book", clinical and epidemiology references on mitigating infectious diseases, Managing Infectious Diseases in Child Care and Schools, Physician's Desk Reference, etc....)	\$100
Emergency Prophylaxis	Emergency prophylaxis for outbreaks and events (i.e. Ciprofloxacin, Doxycycline, Amoxicillin, Tamiflu). Emergency prophylaxis will only be purchased for first responders).	\$1,500
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 emergency preparedness, public health, High Consequence Infectious Diseases, food borne illness, core program subjects etc; printing of employee business cards, as needed.	\$200
CPR Training Costs	Training for grant employees and MRC members to obtain essential CPR skills. This training will ensure responder safety and health at PODs, alternate dispensing locations, and other locations that may utilize the MRC volunteers. Training will prepare public health agency staff and MRC volunteers responding to an incident. (10 CPR cards x \$25 each = \$250)	\$250
MRC Training	Cost to bring outside training, speakers, and training supplies to support grant functions	\$2,000
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$14,224

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
			0.00			SalaryWage Total	\$0

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 - Dr. Sadia Siddiqui, Health Authority	N	Collaborates with Epidemiology department and performs Health Authority duties for PHEP	0.17	NA	\$20,704	12	\$40,994
MATCH - Jarrad Winman, Accountant/Auditor	N	Completes FSRs and maintains fiscal auditing documentation	0.05	NA	\$6,089	12	\$3,950
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
SalaryWage Total							\$44,944

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>	
	Fringe Benefit Rate %
	25.22%
	Fringe Benefits Total
	\$11,335

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

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	
				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

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
				\$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

Total Amount Requested for Equipment:

\$0

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

Total Amount Requested for Other:

\$0