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	$280,180	$280,180	$0	$0	$0	$0
B. Fringe Benefits	$123,363	$123,363	$0	$0	$0	$0
C. Travel	$27,085	$27,085	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$82,144	$82,144	$0		$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$191,545	$191,545	$0	$0	$0	$0
H. Total Direct Costs	$704,317	$704,317	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0		$0	$0
J. Total (Sum of H and I)	$704,317	$704,317	$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 Catetory	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	**Personnel**	**$280,180**	**$280,180**	**Fringe Benefits**	**$123,363**	**$123,363**
	Travel	**$27,085**	**$27,085**	**Equipment**	**$0**	**$0**
	Supplies	**$82,144**	**$82,144**	**Contractual**	**$0**	**$0**
	Other	**$191,545**	**$191,545**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$704,317**	**Budget Total**	**$704,317**

*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

PERSONNEL 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
Epidemiologist	Y	Conducts Field Investigations to provide disease intervention and field rapid tests for HIV and syphillis, partner elicitation/notification	1.00	NA	$5,549.00	10	$55,490
Epidemiologist	Y	Conducts Field Investigations to provide disease intervention and field rapid tests for HIV and syphillis, partner elicitation/notification	1.00	NA	$5,549.00	10	$55,490
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	$5,549.00	10	$55,490
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	$5,549.00	10	$55,490
Program Coordinator	Y	Coordinates DIS grant deliverables & activities; supports grant functions related to DIS	1.00	NA	$5,822.00	10	$58,220
							$0
							$0
							$0
							$0
							$0
							$0

							$0
							$0
					TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS		$0
						SalaryWage Total	$280,180

FRINGE BENEFITS 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 %	44.03%
	Fringe Benefits Total	$123,363

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: Days/Employees	Travel Costs	
In State Conferences/Trainings	Staff to attend to find new innovated information and skills to assist in the investigation of HIV/STD, public health follow up activities	TBD	4 days/5 staff	Mileage	$500
				Airfare	$2,500
				Meals	$1,220
				Lodging	$2,480
				Other Costs	$500
				Total	$7,200
STD Engage, or similar conference	Network with other STD/HIV programs at a national level; Receive updates on goals, objectives, and new treatment information on STD and HIV from CDC and NCSD (National Coalition of STD Directors)	Washington, D.C.	4 days/5 staff	Mileage	$300
				Airfare	$3,000
				Meals	$1,730
				Lodging	$6,500
				Other Costs	$750
				Total	$12,280
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	$0
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Revised: 7/6/2009

Total for Conference / Workshop Travel $19,480

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.	12000	$0.585	$7,020		$7,020
Local training travel including day travel throughout DFW metroplex.	1000	$0.585	$585		$585
			$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 $7,605

Other / Local Travel Costs: $7,605 **Conference / Workshop Travel Costs:** $19,480 **Total Travel Costs:** **$27,085**

Indicate Policy Used: **Respondent's Travel Policy** Yes **State of Texas Travel Policy**

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.

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
TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS				$0

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 [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
Computer-Tablets x5 including docking station, key board, mouse, and two monitors; ($2937 each/unit x 5 = $14685)	Computers to used by health department staff for public health operations.	$14,685
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	Items to include Business Card Holders ($6/unit x 5); File Organizers ($15/unit x 15); Wall File Organizer ($17/unit x10); Bookends ($14/unit x 10); Desk Trays ($21/unit x 5); Writing Legal Pads Pack ($50/unit x 1); Mouse Pads ($6/unit x 5); Permanent Colored Markers ($8/unit x 5); Dry-Erase Markers ($5/unit x 9); Stapler ($13/unit x 5); Staples Pack ($10/unit x 5); Drawer Organizer ($16/unit x 5); Correction Fluid ($4/unit x 5); Planners ($30/unit x 5); 3-ring Binders ($3/unit x 10); Sticky Note Pack ($20/unit x 5); Tape Dispensers ($8/unit x 5); Scotch Tape Pack ($13/unit x 5); Office Scissors ($12/unit x 5); Paper Clip Holder ($6/unit x 5); Binder Clips Box ($20/unit x 1); Paper Clips ($5/unit x 5); Label Maker ($40/unit x 1); ($6/unit x 5); Hole Punchers ($30/unit x 5); Push Pins ($5/unit x 5); File Boxes ($33/unit x 5); Mobile Folding Cart with Lid ($30/unit x 5); Folder Dividers ($6/unit x 5); All-Purpose Cleaner Box ($40/unit x 1); Wastebasket ($10/unit x 5); Printer Paper Box ($75/unit x 10) = $3000.00 and other supplies for staff, to include surge staff that would assist DIS program in case of outbreak response, to produce reports, documentation, and support grant functions and operations.	$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 10 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.	$20,833
Test kits (e.g., syphilis, HIV rapid); Estimate about 300 kits per month at an average of $10/kit. ($10/unit x 300/month x 10 months = $18000)	For specimen collection conducted by DIS when conducting public health follow-up to facilitate case finding and partner services activities.	$30,000

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
Transport Coolers for DIS Program; ($900/unit x 4 = $3600)	Medical-grade coolers and freezers for transporting blood products and specimen for field investigations and emergency events.	$3,600
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$82,144**

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
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						$0

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

Revised: 7/6/2009

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 ($300/unit x 6 FTEs = $1800)	Uniforms for program staff that will be involved in daily HIV/STD program activities to ensure staff & patient safety.	$1,800

Printing and Communication Materials	Printing for additional grant related activities, events and public education or other outreach brochures, flyers, and other materials to educate the public; printing of employee business cards, as needed; Brochures ($0.30/unit x 5000 = $1500), Flyers ($0.25/unit x 4000) = $1000, Employee business cards ($0.20/unit x 2500 = $500)	$3,000
Postage	Postage for outreach materials, mailings, and communications with stakeholders. (Monthly postage costs $0.65/unit x 150 units per month x 10 months = $975.00)	$975
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 ($660 x 5 = $3300)	Voice and Data Plans for cell phones for communication with clients in the field while conducting public health follow-up activities.	$3,300
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), Phlebotomony ($1000/unit x 5 FTEs = $5000), and other DIS trainings.	$10,000
Software for building DIS 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.	$28,389
Office Furniture	Furniture for staff conducting DIS activities to include support staff for grant program; 5x office desks ($7087/unit), 5x office chairs ($465/unit)	$37,760
Dues & Subscriptions	Reference and subscription materials regarding public health for news and studies for overall awareness of current trends and issues (i.e. STD/HIV Prevention, etc.)	$5,000
Conference registration fees	STD Engage or similar conferences to receive updated goals, objectives, and treatment information on HIV/STD ($600/unit x 5)	$3,000

Conference registration fees	Diseases in Nature or similar DIS conference registration costs to received updated goals, objectives, and disease information on communicable diseases ($500/unit x 5)	$2,500
Vehicle Rentals; This is a monthly rental expense of $1700 per month, per vehicle ($1700 x 2 x 10 = $34000)	Renting of two vehicles to be used by staff to conduct field investigation activities;	$34,000
Fuel supply for vehicles ($200/month x 2 x 10 = $4000)	Fuel supply for vehicles that will support the critical functions of grant and staff activities.	$4,000
Specimen Collection Laboratory Fees ($200/unit x 150 lab submissions = $30000.00)	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.	$30,000
Medical Waste Pickup Service Fees; Estimated $459.75/month service fee x 10 months	Waste disposal service fees for the DIS program's medical/biohazard waste.	$4,598
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$14,888

Total Amount Requested for Other: **$191,545**

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

PERSONNEL 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
							$0
					SalaryWage Total		$0

Revised: 7/6/2009

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

Legal Name of Respondent: Collin County Health Care Services

PERSONNEL 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
							$0
					SalaryWage Total		$0

Revised: 7/6/2009

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	
				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: 7/6/2009

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: 7/6/2009

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	
				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: 7/6/2009

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: 7/6/2009

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.

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**

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.

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**

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**

Revised: 7/6/2009

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**

Revised: 7/6/2009

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

Total Amount Requested for CONTRACTUAL: $0

Revised: 7/6/2009

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

Total Amount Requested for CONTRACTUAL: $0

Revised: 7/6/2009

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**
DIS Workstation Carts	Workstation carts for clinical use to be used by program staff and for STD outbreak preparedness in case of surge cases, investigations, field testing. ($500/unit x 10)	$5,000
Specimen Refrigerator	One-time purchase. Specimen refrigerator for clinical use to be used by program staff and for STD outbreak preparedness in case of surge cases, investigations, field testing.($4000/unit x 1)	$4,000
Specimen Freezer	One-time purchase. Specimen freezer for clinical use to be used by program staff and for STD outbreak preparedness in case of surge cases, investigations, field testing. ($4000/unit x 1)	$4,000
Training Software	Software necessary to facilitate in-house CPR training, DIS training, and other critical public health trainings.	$1,000
Data Service Plans for DIS Tablets	Tablet Data Service Plan for DIS grant activities; Equipment is necessary for secure network functions and mobile data entry for field visitations. ($444/unit x 2 = $888)	$888

Revised: 7/6/2009

Total Amount Requested for Other:	**$14,888**

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

Revised: 7/6/2009