CY2023- TB/Fed Budget

TB/PC FED

Applicant Information

Legal Name of Applicant Agency:	Collin County
Mailing Address:	
Street / PO Box:	825 N. McDonald #130
City:	McKinney
Zip:	75069
Payee Name:	Collin County
Payee Mailing Address:	
Street / PO Box:	825 N. McDonald #130
City:	McKinney
Zip:	75069
State of Texas Comptroller Vendor ID # (11 digit + 3 digit mail code)**:**	
UEID Number (Replacing DUNS number)	74873449
Fiscal Year-End Date (MM/DD)	12/31

Type of Entity (Choose one) — Click on appropriate box

- [ ] City:
- [x] County:
- [ ] Other Political Subdivision:
- [ ] Nonprofit Organization
- [ ] Community-Based Organization
- [ ] Hospital
- [ ] State Controlled Institution of Higher Learning
- [ ] Other
- [ ] Faith Based (Nonprofit Org)

Contract Term:	
Start Date:	1/1/2023
End Date:	12/31/2023
State-wide or Counties Served	
State-wide or County(ies) Served:	Collin County
Amount of Funding Allocated:	$84,572.00

CONTACT PERSON INFORMATION

Legal Business Name: Collin County

This form provides information about the appropriate contacts in the contractor's organization. If any of the following information changes during the term of the contract, please send written/e-mail notification to the Assigned Contract Manager.

Health Director / CEO / Executive Di CANDY BLAIR
Direct Phone: 972-548-5504 Ext:
E-mail: CBLAIR@CO.COLLIN.TX.US
Mailing Address (street, city, county, & zip): 825 N. MCDONALD #130, MCKINNEY, TX 75069

B-13 Submitter: Andrea Pease
Direct Phone: 972-548-4732 Ext:
E-mail: apease@co.collin.tx.us
Mailing Address (street, city, county, & zip): 2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Program Lead Person: Candice Akins
Direct Phone: 972-548-5509 Ext:
E-mail: cakins@co.collin.tx.us
Mailing Address (street, city, county, & zip): 825 N. MCDONALD #130, MCKINNEY, TX 75069

Contract Lead Person: Christian Jimenez
Direct Phone: 972-548-5619 Ext:
E-mail: cjimenez@co.collin.tx.us
Mailing Address (street, city, county, & zip): 825 N. MCDONALD #130, MCKINNEY, TX 75069

Contract Authorized Signatory: CHRIS HILL
Direct Phone: 972-548-4632 Ext:
E-mail: CHILL@CO.COLLIN.TX.US
Mailing Address (street, city, county, & zip): 2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Additional Contract Authorized Sign
Direct Phone: Ext:
E-mail:
Mailing Address (street, city, county, & zip):

FFATA/Assurances Signatory: Andrea Pease
Direct Phone 972-548-5619 Ext:
Mailing Address (street, city, county, & zip):

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	$68,954	$57,374			$11,580	
B. Fringe Benefits	$31,715	$26,381			$5,334	
C. Travel	$817	$817			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$0	$0			$0	
F. Contractual	$0	$0			$0	
G. Other	$0	$0			$0	
H. Total Direct Costs	$101,486	$84,572	$0	$0	$16,914	$0
I. Indirect Costs	$0	$0				
J. Total (Sum of H and I)	$101,486	$84,572	$0	$0	$16,914	$0
				Match Percentage	20.00%	

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
Dawn West - Registered Nurse (RN) (ID: 300161)	N	Provides TB case management services as a registered nurse	0.43	License	$7,242	12	$37,369
Cynthia Leung - Medical Assistant (ID: 300176)	N	Serves as TB case registrar, performing TB data collection and reporting duties	0.43	N/A	$3,877	12	$20,005
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS							$0
					SalaryWage Total		$57,374

FRINGE BENEFITS Itemize the elements of fringe benefits in the space below:

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1300 for medical/dental/RX and $4.95 for term life per month), Long Term Disability (salary x 0.0024), Short Term Disability $2.10/month, Long Term Care $30.08/month, Retirement (salary x 0.08), Unemployment Insurance (salary x 0.001)

Total Number of FTEs:	**0.86**	Fringe Benefit Rate %	45.98%
		Fringe Benefits Total	$26,381

TRAVEL Budget Category Detail Form

Legal Name of Respondent: Collin County

Conference / Workshop Travel Costs

Description of Confrence/Workshop *Please break this out per traveler, per category. Identify "in-kind" personnel traveling that are not listed on the personnel tab.	Justification	Location City/State	Number of: Days & Employees	Travel Costs	
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Revised: 3/25/2014

Total for Conference / Workshop Travel $0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Local travel for staff (Dawn West (RN), Cynthia Leung (Medical Assistant), Elvia Priest (TB Outreach Worker) to conduct contact investigations, screening,	1000	$0.625	$625		$625
Local training travel to cover staff (Dawn West (RN), Cynthia Leung (Medical Assistant), Elva Priest (TB Outreach Worker) expenses including day travel for	307	$0.625	$192		$192
			$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 $817

Other / Local Travel Costs: $817 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** **$817**

Revised: 3/25/2014

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

Current GSA Travel Rates can be found here

****Provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Include the cost of ground transportation when applicable.**

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

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

Revised: 3/25/2014

SUPPLIES Budget Category Detail Form

Legal Name of Respondent: Collin County

Itemize and describe each supply item and **provide an estimated quantity and cost (i.e. #of boxes & cost/box) if applicable.** Provide a justification for each supply item. Costs may be categorized by each general type (e.g., office, computer, medical, educational, etc.)

Description of Item Provide estimated quantity and cost (i.e. # of boxes & cost/box)	Purpose & Justification	Total Cost

Revised: 3/25/2014

		TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

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

****Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.**

CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: <u>Collin County</u>

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	METHOD OF SELECTION	PERIOD OF PERFORMANCE	DESCRIPTION OF SERVICES / SCOPE OF WORK	METHOD OF ACCOUNTABILITY	BUDGET DETAIL AND 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
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS									$0

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

Revised: 3/25/2014

OTHER COSTS Budget Category Detail Form

Legal Name of Respondent: Collin County

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

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

****Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If not, include additional justification. For printing costs, identify the types and number of copies of documents to be printed.**

Revised: 3/25/2014

Indirect Costs

Legal Name of Respondent: Collin County

Total amount of indirect costs allocable to the project: **Amount:** $0

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 (Indirect Costs)**	**RATE:**	**EXAMPLE** 8.75%
	BASE:	**EXAMPLE** - Modified total direct, including subgrants and subcontracts up to the first $25,000; excluding equipment, capital equipment, as well as the portion of each subgrant and subcontract in excess of $25,000.00.

INSTRUCTIONS *: Organizations that have an approved indirect cost rate should complete the section above by marking the box and indicating the rate and base. A copy of the approved rate agreement that will be in effect during the contract term should be submitted with the Budget Templates. If a rate agreement is pending, submit the latest approved agreement.*

I attest that I have not had an approved indirect cost rate and I am requesting/electing to utilize the de minimis indirect cost rate.

I elect not to request indirect costs.

Revised: 3/25/2014

SUPPLEMENTAL and MATCH FORMS INSTRUCTIONS

The budget templates include a SUPPLEMENTAL and a MATCH page (one per budget category) that are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template. The MATCH pages (one per budget category) are intended to record the required match will be utilized to list detail information for the required match.

The amounts on each supplemental template will automatically populate from the templates and will be inserted on the last line of the primary budget template.

The amounts on each match template will automatically populate from the templates and will be inserted in column labeled "Local Funding Sources (5)"

The SUPPLEMENTAL and MATCH budget templates are:

Personnel Supplemental
Travel Supplemental
Equipment & Controlled Assets Supplemental
Supplies Supplemental
Contractual Supplemental
Other Costs Supplemental

Personnel Match
Travel Match
Equipment & Controlled Assets Match
Supplies Match
Contractual Match
Other Costs Match

PERSONNEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: Collin County

PERSONNEL Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)	Estimated Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
			0.00				
					SalaryWage Total		$0

PERSONNEL Budget Category Detail Form (Match)

Legal Name of Respondent: Collin County

PERSONNEL Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)	Estimated Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Elva Priest - TB Outreach (ID: 201476)	N	Provides DOT to TB Patients	0.18	NA	$5,436	12	$11,580
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$11,580

FRINGE BENEFITS **Itemize the elements of fringe benefits in the space below:**

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1300 for medical/dental/RX and $4.95 for term life per month), Long Term Disability (salary x 0.0024), Short Term Disability $2.10/month, Long Term Care $30.08/month, Retirement (salary x 0.08), Unemployment Insurance (salary x 0.001)

Fringe Benefit Rate %	46.06%
Fringe Benefits Total	$5,334

TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: Collin County

Conference / Workshop Travel Costs

Description of Confrence/Workshop *Please break this out per traveler, per category. Identify "in-kind" personnel traveling that are not listed on the personnel tab.	Justification	Location (City, State)	Number of: Days & Employees	Travel Costs	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0

Total for Conference / Workshop Travel $0

Revised: 3/25/2014

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0

Total for Other / Local Travel $0

Other / Local Travel Costs: $0 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** **$0**

TRAVEL Budget Category Detail Form (Match)

Legal Name of Respondent: Collin County

Conference / Workshop Travel Costs

Description of Confrence/Workshop *Please break this out per traveler, per category	Justification	Location (City, State)	Number of: Days & Employees	Travel Costs	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0

Total for Conference / Workshop Travel $0

Revised: 3/25/2014

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0

Total for Other / Local Travel $0

Other / Local Travel Costs: $0 Conference / Workshop Travel Costs: $0 **Total Travel Costs:** **$0**

Revised: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category
Detail Form (Supplemental)

Legal Name of Respondent: Collin County

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0

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

Revised: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category
Detail Form (Match)

Legal Name of Respondent: Collin County

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0

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

Revised: 3/25/2014

SUPPLIES Budget Category Detail Form (Supplemental)

Legal Name of Respondent: Collin County

Itemize and describe each supply item and **provide an estimated quantity and cost (i.e. # of boxes & cost/box) if applicable**. Provide a justification for each supply item. Costs may be categorized by each general type (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item Provide estimated quantity and cost (i.e. # of boxes & cost/box)	Purpose & Justification	Total Cost

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

Revised: 3/25/2014

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 Provide estimated quantity and cost (i.e. # of boxes & cost/box)	Purpose & Justification	Total Cost

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

Revised: 3/25/2014

CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: Collin County

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that de

CONTRACTOR NAME (Agency or Individual)	METHOD OF SELECTION	PERIOD OF PERFORMANCE	DESCRIPTION OF SERVICES / SCOPE OF WORK	METHOD OF ACCOUNTABILITY	BUDGET DETAIL AND JUSTIFICATION	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0

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

CONTRACTUAL Budget Category Detail Form (Match)

Legal Name of Respondent: **Collin County**

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as “To Be Named.” Justification for any contract that de

CONTRACTOR NAME (Agency or Individual)	METHOD OF SELECTION	PERIOD OF PERFORMANCE	DESCRIPTION OF SERVICES / SCOPE OF WORK	METHOD OF ACCOUNTABILITY	BUDGET DETAIL AND JUSTIFICATION	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0
									$0

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

OTHER COSTS Budget Category Detail Form (Supplemental)

Legal Name of Respondent: Collin County

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

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

Revised: 3/25/2014

OTHER COSTS Budget Category Detail Form (Match)

Legal Name of Respondent: Collin County

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

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

Revised: 3/25/2014