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 that is locaated 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 Grant Technical Assistance Guide (GTAG) located at the following web site:
https://www.dshs.texas.gov/contracts/gtag.aspx

FORM I: 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 Sources (5)	Other Funds (6)
A. Personnel	$1,313,959.22	$1,313,959.22	$0	$0		$0
B. Fringe Benefits	$520,841.43	$520,841.43	$0	$0		$0
C. Travel	$4,038.00	$4,038.00	$0	$0		$0
D. Equipment	$13,014.22	$13,014.22	$0	$0		$0
E. Supplies	$96,271.42	$96,271.42	$0	$0		$0
F. Contractual	$0.00	$0.00	$0	$0		$0
G. Other	$47,307.71	$47,307.71	$0	$0		$0
H. Total Direct Costs	$1,995,432.00	$1,995,432.00	$0	$0		$0
I. Indirect Costs	$0.00	$0.00	$0	$0		$0
J. Total (Sum of H and I)	$1,995,432.00	$1,995,432.00	$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**	**$1,313,959.22**	**$1,313,959.22**	**Fringe Benefits**	**$520,841.43**	**$520,841.43**
	Travel	**$4,038.00**	**$4,038.00**	**Equipment**	**$13,014.22**	**$13,014.22**
	Supplies	**$96,271.42**	**$96,271.42**	**Contractual**	**$0.00**	**$0.00**
	Other	**$47,307.71**	**$47,307.71**	**Indirect Costs**	**$0.00**	**$0.00**

TOTAL FOR:	**Distribution Totals**	**$1,995,432.00**	**Budget Total**	**$1,995,432.00**

*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

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
Financial Analyst (Christian Jimenez)	N	Assist with grant performance goals and deliverables, supports grant functions related to COVID-19	1.00	NA	$5,616.51	36	$202,194.36
Functional Analyst (Crystal Pang)	N	Assist with grant performance goals and deliverables, intregration of technology solutions for vaccine data systems, supports grant functions related to COVID-19	1.00	NA	$5,407.00	36	$194,652.00
Functional Analyst (Patrick Hill)	N	Assist with grant performance goals and deliverables, intregration of technology solutions for vaccine data systems, supports grant functions related to COVID-19	1.00	NA	$5,407.00	21	$113,547.00
Registered Nurse (Elmer Pitalio)	N	Performs COVID-19 vaccine administration, reports vaccine data to the State, requests additional vaccine from State partners, monitors vaccine to ensure vaccine efficacy	1.00	RN	$6,062.00	18	$109,116.00
Registered Nurse (Jacqulyn Griffith)	N	Performs COVID-19 vaccine administration, reports vaccine data to the State, requests additional vaccine from State partners, monitors vaccine to ensure vaccine efficacy	1.00	RN	$5,777.00	22	$127,094.00
Registered Nurse (Komalatha Atluri)	N	Performs COVID-19 vaccine administration, reports vaccine data to the State, requests additional vaccine from State partners, monitors vaccine to ensure vaccine efficacy	1.00	RN	$5,630.00	30	$168,900.00
Registered Nurse (Merhawit Ghebermichael)	N	Performs COVID-19 vaccine administration, reports vaccine data to the State, requests additional vaccine from State partners, monitors vaccine to ensure vaccine efficacy	1.00	RN	$5,630.00	30	$168,900.00

Health Care Analyst (Lesleigh Hash)	N	Performs COVID-19 vaccine administration, reports vaccine data to the State, requests additional vaccine from State partners, monitors vaccine to ensure vaccine efficacy	1.00	NA	$4,233.92	25	$105,848.00
Registered Nurse (Discontinued)	N	Performs COVID-19 vaccine administration, reports vaccine data to the State, requests additional vaccine from State partners, monitors vaccine to ensure vaccine efficacy	1.00	RN	$5,491.83	4	$21,967.32
Registered Nurse (Discontinued)	N	Performs COVID-19 vaccine administration, reports vaccine data to the State, requests additional vaccine from State partners, monitors vaccine to ensure vaccine efficacy	1.00	RN	$5,491.83	6	$32,950.98
Nurse Practitioner (Discontinued)	N	Manages COVID-19 vaccine staff and assists with questions from patients and adverse reactions	1.00	NA	$6,550.08	7	$45,850.56
Medical Assistant (Discontinued)	N	Assist with COVID-19 vaccine data entry, paperwork, and phone calls. May augment medical staff as necessary	1.00	NA	$3,277.00	2	$6,554.00
Medical Assistant (Discontinued)	N	Assist with COVID-19 vaccine data entry, paperwork, and phone calls. May augment medical staff as necessary	1.00	NA	$3,277.00	5	$16,385.00
							$0
					TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS		$0
						SalaryWage Total	$1,313,959.22

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), 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 %	39.64%
	Fringe Benefits Total	$520,841.43

FORM I-2: 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: Days/Employees	Travel Costs	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	
				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 FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Out of office meetings, seminars, exercises, training, including day travel within DFW metroplex. Will be utilized by all staff performing COVID-19 duties.	3082	$0.655	$2,019		$2,019
Long term care or underserviced vaccine outreach visits, visitis for provider education	3082	$0.655	$2,019		$2,019
			$0		$0
			$0		$0
			$0		$0
			$0		$0
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					$0

Total for Other / Local Travel $4,038

Other / Local Travel Costs: $4,038 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** **$4,038**

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

FORM I-3: EQUIPMENT 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. 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
Vaccine Freezer Storage	To store vaccines requiring ultra cold temperature	1	$13,014.22	$13,014.22
				$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: **$13,014.22**

FORM I-4: SUPPLIES Including CONTROLLED ASSETS 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.) 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 X 10 included docking station, keyboard, stylus, mouse, and two monitors; $2006.31 each package	Computers to be used by health department staff for vaccine support operations.	$20,063.10
Cell Phone-Voice and Data X 9 includes standard mobile phone, case, screen protector, and car charger; $117 ea	Cell phones to be used by health department staff to communicate with patients, healthcare providers and others regarding vaccine operations.	$1,053.00
Cell Phone Service Plans X 7 employees for 2 year and 2 employees at 3 years annual cost of voice and data plan $576 ea; total accumulated cost estimated at $5375.14	Cell phone voice and data service plan to be used by health department staff using their cell phones to communicate with patients, healthcare providers and others regarding disease investigations	$5,375.14
Scanner - Top Feed X 9; county standard desktop scanner; $869.99 ea	Scanners to be used by vaccine support staff to produce electronic files for retention of disease investigation reports and related documents	$7,829.91
Office Supplies	Clipboards, paper, writing utensils, labels, folders, binders, etc…to produce reports, documentation, and support grant functions.(Individual supply items will not exceed $499.00)	$3,553.13
Ultra-low cold data logger kits and recalibration, primary and backups x 6; $154.66 ea logger, $90.84 for recalibration as needed	Data loggers for ensuring temperature stability for vaccine products. Recalibration every two years to ensure data loggers are performing appropriately.	$1,018.84
Personal Protective Equipment (PPE) - type of product, pricing per item and quantities estimated and will vary	PPE to be used as protective barrier by staff providing vaccination services and those with support roles. Items will include those not provided in vaccine shipments and those needed by ancillary staff such as front counter staff. These supplies may include gloves, masks, and similar items for use in vaccine clinics over 2 years of operations.	$10,000.00
Supplies used for dispensing COVID vaccine --type of product and pricing per item and quantities estimated and will vary	Items necessary for vaccination operations to be used by staff members involved in the administration of vaccines to the public. Items may include trash liners, biohazard bags, gauze, needles, crash carts, hand sanitizer, sharps containers, and epi pens for use over 2 years of operations.	$19,998.38
Printing and Communication Materials	Printing for additional grant related activities, events and public education or other outreach brochures, flyers, postcards, coloring books, posters and other materials to educate the public; printing of employee business cards, as needed.	$4,525.56
Computer-Tablets X 9 with accessories at $2,094.93 each	Computers to be used by health department staff for vaccine support operations and all necessary accessories	$18,854.37
Mobile computer charging station/dock	Cost for multi-computer charging station for 10 computers that are used for mobile vaccination clinics	$1,149.99
Fuel Supply for Rental Vehicle (estimated $150/month x 19 months)	Fuel for rental car for staff to conduct grant activities	$2,850.00
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$96,271.42**

FORM I-5: 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., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly rate, unit rate, lump sum amount)	TOTAL
None						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

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

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: **COLLIN COUNTY HEALTH CARE SERVICES**

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	**Purpose & Justification**	**Total Cost**
MiFi Device and Service Plan for x 7 staff 2 years and for 2 staff for 3 years; MiFi Device cost $0, annual cost of MiFi service $444 ea	MiFi Devices for additional staff	$1,002.34
Software-EA licenses X 19 includes Microsoft Office Suite; $505.89 ea to install on tablets	Computer software to be used by health department staff to communicate by email, produce vaccine operation	$9,611.91
Software- Wello Temperature Scanning	Software service annual fee for Wello temperature checks for COVID-19 appointment check-ins for patients	$4,800.00
Office chairs for staff at $381.88 per chair X 9 employees	Cost for office chairs for staff to have at desk area	$3,436.92
Data cards for mobile vaccine computers to use at clinics x 10 at $444 each annually, for two years	Data cards (with data plan) for computers/tablets for vaccine appointments	$1,002.34
Jotform Software Licenses	Jotform software expenses for grant staff to create and organize grant forms	$3,792.00
Adobe DC Licenses ($86.22/unit x 10) for grant computers	Adobe software licenses for grant staff computer laptops	$862.20
Rental vehicle ($1200/month x 19 months) for grant staff and activities	Rental vehicle for program outreach and grant-related activities	$22,800
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$47,307.71**

FORM I - 7 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 (Form I - 7 Indirect)**	**RATE:** **BASE:**
____	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.	

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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

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

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

Legal Name of Respondent: COLLIN COUNTY

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

FORM I-2: 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
				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 $0

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

FORM I-2: TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: COLLIN COUNTY

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

Other / Local Travel Costs

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

Total for Other / Local Travel $0

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

FORM I-3: EQUIPMENT 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

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

FORM I-3: EQUIPMENT 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

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

FORM I-4: SUPPLIES including CONTROLLED ASSETS 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 [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**

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

FORM I-4: SUPPLIES including CONTROLLED ASSETS 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 [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**

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

FORM I-5: CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: COLLIN COUNTY

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

FORM I-5: 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 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

FORM I-6: OTHER 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**

FORM I-6: OTHER 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**

FORM I - 7 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 (Form I - 7 Indirect)**	**RATE:** **BASE:**
____	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.	

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