Legal Name
Mailing Address:
Payee Name:
Payee Mailing Address:
State of Texas Comptroller Vendor ID # (9 digit + 3 digit mail code):
Unique Entity Identifier (UEI)
Type of Entity (Choose one)
Counties Served
Amount of Funding Allocated
Point of Contacts (POCs)
Authorized Signatory
Additional Authorized Signatory
DocuSign CC
Emergency Contact
Funding Categories
Conference & Workshops
Mileage Only
Policy
Name and Functional Title
Vacant
Job Summary
FTEs
Certifications & License
Estimated Monthly Wage
Number of Months
Salary/Wages

Fringe
Description of Items
Purpose & Justification
Number of Units
Cost Per Unit
Total Cost
Equipment
Description of Items
Purpose & Justification
Total Cost
The “Supplies” budget category is comprised of the following two separate and distinct components:
Contractor Name
Description of Services
Justification
Method of Payment
Number of Payments
Rate of Payment
Total Cost
Contractual
Description of Items
Purpose & Justification
Total Cost
Other

Indirect costs are those costs incurre
Attachment) and not readily assignab
practices of organizations, it is not pc
typical examples of indirect costs ma
such as salaries and expenses of exec

Budget Instructions by Category
Face Page
Full legal name is required (no abbreviations). Check past contracts to verify this is correct.
Include the full mailing address.
Name of the person or entity where payments will be sent/received.
Include the full payee mailing address.
DSHS assigns this number. The **TIN** and **MAIL CODE** are both requirement.
Your Unique Entity Identification (UEI) code can be located on SAM.GOV. It is required that you have a registered and active account on SAM.gov, if receiving federal funding.
A entity type must be checked.
Counties must be listed.
The funding amount should match the total allocation on the budget summary page.
Contact Page
Add a point of contact as applicable for each category on the contact page.
This contact is require and should be the person who signs the contract.
This contact is not required, unless they are different then the authorize signatory and are responsible for filling out the FFATA, Assurances, Lobbying, DUA etc..
This contact is not required, but contractors can include a cc person to be notified when the contracts
This contact is required.
Budget Summary
The summary must reflect the correct funding for each category. This information automatically rolls
Travel
Sections are only required, if the contractor lists confrences or workshops. The description must be detailed and include as much information as possible. The contractor cannot add TBD to the
Sections are only required, if the contractor lists milage only travel. The contractor can use their internal policy or the DSHS policy, but this must be marked in the budget (bottom of the travel page). If
A travel policy must be check at the bottom of the travel page. The contractor can use their internal policy or the DSHS policy. If you they choose to use their internal policy a copy if required for their file.
Personnel
Include a name and job title for each staff. If the job is vacant, add TBD for the name, but there should always be a title. A single staff cannot be listed under multiple job titles.
Must choose Yes or No.
This section must include a clear and accurate job summary for each employee.
An FTE must be included. No one person can have more than 1 FTE.
This section should list any required certificates or licenses. If none are required, it should be marked
The estimated monthly wage is required for each staff listed.
The number of months are required for each staff listed.
The FTE - Monthly Salary Wage -Number of Month make up the salary amount for each staff.

A list of the fringe benefits is required. Fringe benefits are allowances and services provided by the organization to its employees as compensation in addition to regular salaries and wages. Fringe benefits include, but are not limited to, the employer portion of FICA and Medicare, the cost of employee insurance, pensions, and unemployment benefit plans. The cost of fringe benefits is allowable (in proportion to the amount of time or effort employees devote to the DSHS-funded
Equipment
A description of items is required.
A justification is required.
Required
Required
The total cost must include a combined total for all units being purchased.
Equipment - defined as tangible nonexpendable personal property with an acquisition cost of $5,000 or more and a useful life of more than one year.
Supplies
A detailed description of items is required.
A detailed justification is required.
Required
Medical Supplies are allowable such as needles, syringes etc..
Add to the end of your supplies description "No one item will exceed $499.00."
Consumable Supplies - defined as consumable items that are directly associated with the Program Attachment's Statement of Work and are necessary to carry out the activities stated in the Program Attachment.
If you have a controlled assets add to the end of your description "No one item will exceed $4,999."
Controlled Assets - defined as nonexpendable, tangible personal property having a useful lifetime of more than one year and an acquisition cost of $500 or more, but less than $5,000.
Contractual
Required
A detailed description of items is required.
A detailed justification is required.
Required
Required
Required
Required
The "Contractual" category should include all contracts for the provision of goods and/or services that are directly associated with carrying out the Statement of Work. This includes – contracts that delegate substantive portions of the Statement of Work or convey property to a third
Other
A detailed description of items is required.
A detailed justification is required.
Required
All other allowable direct costs not listed in any of the above categories are to be included in the "Other" category. This includes vendor contracts for goods and services which are acquired for general use of an organization. Some of the costs listed below may be treated as indirect cost. Their

Indirect
d for a common or joint purpose benefiting more than one cost objective (i.e., DSHS Program ole to the cost objectives specifically benefitted. Because of the diverse characteristics and accounting ossible to specify the types of cost that may be classified as indirect cost in all situations. However, y include central service costs of a governmental unit; general administration and general expenses cutive officers, personnel administration, accounting, and contracted administrative services;

TEXAS Department of State Health Services

FY2024

Contract Type: CPS/Hazards

Applicant Information

Legal Name of Applicant Agency:	COLLIN COUNTY
Mailing Address:	
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)**:**	17560008736026
Unique Entity Identifier (UEI) This is a required field, if receiving federal funding. The Unique Entity Identification code can be located on Sam.gov):	S1ETLA9BNCC5

Type of Entity (Choose one)

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

Project Period

Start Date:	7/1/2023
End Date:	6/30/2024

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			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-5504	Ext:		
Fax:				
E-mail:	cblair@co.collin.tx.us			825 N. MCDONALD ST #130, MCKINNEY, TX 75069
B-13/FSR Rep:	Andrea Pease			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4732	Ext:		
Fax:				
E-mail:	apease@co.collin.tx.us			2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069
PHEP (HAZARDS) Program Leader:	Meredith Nurge			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4708	Ext:		
Fax:				
E-mail:	mnurge@co.collin.tx.us			825 N. MCDONALD ST #130, MCKINNEY, TX 75069
SNS (CRI) Coordinator:	Amy Davis			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4473	Ext:		
Fax:				
E-mail:	aldavis@co.collin.tx.us			825 N. MCDONALD ST #130, MCKINNEY, TX 75069
Authorized Signatory for **DocuSign**	Chris Hill			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4623	Ext:		
Fax:				
E-mail:	chill@co.collin.tx.us			2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069
Additional Authorized Signatory for **DocuSign only if applicable (FFATA, Certs, etc)**	Andrea Pease			
Phone:	972-548-4732	Ext:		
Fax:				
E-mail:	apease@co.collin.tx.us			
DocuSign "CC" Person	Eric Dickey			
Phone:	972-548-5696	Ext:		
Fax:				
E-mail:	edickey@co.collin.tx.us			
Emergency Contact	Taylor Burton			Mailing Address (street, city, county, state, & zip):
Cell Phone:	214-973-2023	Ext:		
Fax:				
E-mail:	tburton@co.collin.tx.us			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	$434,672	$390,632			$44,040	
B. Fringe Benefits	$168,257	$156,018			$12,239	
C. Travel	$11,936	$11,936			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$1,800	$1,800			$0	
F. Contractual	$0	$0			$0	
G. Other	$2,400	$2,400			$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	$6,871	12	$82,452
Jerry Joseph, PHEP Planner	N	Performs PHEP activities to include supporting planning needs, partnering with stakeholders, and other grant functions	1.00	NA	$5,761	12	$69,132
Mandie Sosa, Administrative Secretary	N	Provides administrative support for the PHEP team	0.10	NA	$5,324	12	$6,389
Aubrey Saylor, PHEP Planner	N	Performs PHEP activities to include supporting planning needs, partnering with stakeholders, and other grant functions	0.85	NA	$6,780	12	$69,156
Jawaid Asghar, Chief Epidemiologist	N	Coordinates epidemiology services and disease investigation	0.70	NA	$9,993	12	$83,941
Susana Ramos, Health Care Analyst	N	Performs disease & contact investigations, influenza surveillance, PEP distribution	1.00	NA	$6,111	12	$73,332
Vada Caffery, Administrative Secretary	N	Provides administrative support for the Epidemiology team	0.10	NA	$5,192	12	$6,230
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS			$0
					SalaryWage Total		$390,632

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

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1,400 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/month, Retirement (salary x 0.095), Unemployment Insurance (salary x 0.001). Per life insurance HR, the calculation should be employees salary x 1.5 and then multipied by 0.085 to include AD&D.

Total Number of FTEs:	**4.75**		**Fringe Benefit Rate %**	39.94%
			Fringe Benefits Total	$156,018

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	
Semiannual PHEP Contractor Meeting (two meetings)	Required contractor meeting conducted by DSHS	Austin, TX	2 meetings / 2 days / 1 employee	Mileage	$1,000
				Airfare	$0
				Meals	$450
				Lodging	$450
				Other Costs	$100
				Total	$2,000
NACCHO Conference	Conference for public health and emergency preparedness professionals	Atlanta, GA	7 days/2 employee	Mileage	$80
				Airfare	$1,800
				Meals	$975
				Lodging	$2,675
				Other Costs	$325
				Total	$5,855
Texas Emergency Management Conference	Conference for public health and emergency preparedness professionals	Ft Worth, TX	6 days/2 employee	Mileage	$500
				Airfare	$0
				Meals	$700
				Lodging	$2,000
				Other Costs	$225
				Total	$3,425
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $11,280

Revised: 3/25/2014

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 the State of Texas. Will be utilized by all PHEP funded staff.	1002	$0.655	$656		$656
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					$0

Total for Other / Local Travel $656

Other / Local Travel Costs: $656 **Conference / Workshop Travel Costs:** $11,280 **Total Travel Costs:** **$11,936**

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

Revised: 3/25/2014

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
				$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**	**Purpose & Justification**	**Total Cost**
POD Supplies, These include additonal POD signage inside the POD, external signage and drive-thru items (such as cones, stanchions, safety lights, and small barriers, etc.), 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, etc.), and POD inventory supplies (such as inventory marking tools and supplies, etc.). Gloves, masks, crowd control posts, signs, etc., as needed to support various deliverables, dispensing models other than open PODs.	Various supplies for deployable POD kits.	$1,800

	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$1,800**

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
				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
Conference Registration Fees	Registration fees for: registration for NACCHO Preparedness Summit $850 X 2, Texas Emergency Management Conference $350 X 2, or other TBD local area conference fees relevant to the program	$2,400
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$2,400**

Revised: 3/25/2014

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 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
MATCH - Dr. Sadia Siddiqui, Health Authority	N	Collaborates with Epidemiology department and performs Health Authority duties for PHEP	0.16	NA	$22,135	12	$42,499
MATCH - Andrea Pease, Accountant/Auditor	N	Completes FSRs and maintains fiscal auditing documentation	0.02	NA	$6,420	12	$1,541
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$44,040

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

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1,400 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/month, Retirement (salary x 0.095), Unemployment Insurance (salary x 0.001). Per life insurance HR, the calculation should be employees salary x 1.5 and then multipied by 0.085 to include AD&D.

Fringe Benefit Rate %	27.79%
Fringe Benefits Total	$12,239

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	
			1	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

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
				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
				$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 [If applicable, 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 [If applicable, 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)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0

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

CONTRACTUAL Budget Category Detail Form (Match)

Legal Name of Respondent: COLLIN COUNTY

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

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0

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

OTHER COSTS Budget Category Detail Form (Supplemental)

Legal Name of Respondent: COLLIN COUNTY

Description of Item [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