TEXAS Department of State Health Services

FY2022

Contract Type: CPS/PHIG (Year 3)

Applicant Information

Legal Name of Applicant Agency:	Collin County
Mailing Address:	
Street / PO Box:	825 N. McDonald St #130
City:	McKinney
Zip:	TX
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)**:**	17560008736 026
UEI Code (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:	12/1/2024
End Date:	11/30/2025

Counties Served

County(ies) Served:	Collin
Amount of Funding Allocated:	$1,625,736.00

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 #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 #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 #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	Christian Jimenez			
Phone:	972-548-5619	Ext:		
Fax:				
E-mail:	cjimenez@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 #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 (5)	Other Funds (6)
A. Personnel	$410,844	$410,844				
B. Fringe Benefits	$182,136	$182,136				
C. Travel	$0	$0				
D. Equipment	$0	$0				
E. Supplies	$0	$0				
F. Contractual	$0	$0				
G. Other	$0	$0				
H. Total Direct Costs	$592,980	$592,980				
I. Indirect Costs	$0	$0				
J. Total (Sum of H and I)	$592,980	$592,980				

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	$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

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
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					$0

Total for Other / Local Travel $0

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

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

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
Financial Analyst (Christian Jimenez)	N	Assists with grant performance goals and deliverables; supports grant functions and special projects as needed	1.00	NA	$6,632	12	$79,584
Health Care Analyst (Alison Thrasher)	N	Provides administrative support for Epidemiology, Immunizations, and other Health Care programs	1.00	NA	$4,942	12	$59,304
Functional Analyst (Crystal Pang)	N	Assists with management of departmental databases, software, and reporting; Identifies areas for improvement and supports information system projects	1.00	NA	$6,020	12	$72,240
Functional Analyst (Patrick Hill)	N	Assists with management of departmental databases, software, and reporting; Identifies areas for improvement and supports information system projects	1.00	NA	$5,990	12	$71,880
Financial Analyst (Eric Dickey)	N	Assists with grant performance goals and deliverables; supports grant functions and special projects as needed	1.00	NA	$6,096	12	$73,152
Health Care Analyst	Y	Provides administrative support for Epidemiology, Immunizations, and other Health Care programs	1.00	NA	$4,557	12	$54,684
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS			$0
					SalaryWage Total		$410,844

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

a. Fringe Benefits: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1,400 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 per month, Retirement (salary x 0.095), Unemployment insurance (salary x 0.001). Per Collin County HR, the Life Insurance calculation should be rounding-up employee salary then multiply by 1.5, and then multiplied by 0.085 which includes AD&D.

Total Number of FTEs:	**6.00**		**Fringe Benefit Rate %**	44.33%
			Fringe Benefits Total	$182,136

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
	TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS			$0

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

SUPPLIES Budget Category Detail Form

Legal Name of Respondent: **Collin County**

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

Description of Item **Provide estimated quantity and cost**	**Purpose & Justification**	**Total Cost**
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

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

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**

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**

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 INSTRUCTIONS

The budget templates include a SUPPLEMENTAL 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 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 SUPPLEMENTAL budget templates are:

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

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
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							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
			0.00				
					SalaryWage Total		$0

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	$0
				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**

EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Supplemental)

Legal Name of Respondent: Collin County

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

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

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

SUPPLIES Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County**

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

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
		$0

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

CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County**

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

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

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**