



FY24 IMM Locals
Collin County - Immunizations-Locals Contract

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 # (11 digit + 3 digit mail code): 17560008736 026
DUNS # (9 digits required for subrecipient contractors): S1ETLA9BNCC5 (Unique Entity ID)

Fiscal Year-End Date (MM/DD) 08/31

Type of Entity (Choose one)
City: [] Click on appropriate box
County: [x]
Other Political Subdivision: []

Contract Term: Start Date: 9/1/2023
End Date: 8/31/2024

State-wide or Counties Served
State-wide or County(ies) Served: Collin

Amount of Funding Allocated: \$354,062.00

CONTACT PERSON INFORMATION

Legal Business Name: 0

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
Phone: 972-548-5504
Fax:
E-mail: cblair@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD #130, MCKINNEY, TX 75069

B-13/FSR Rep: Andrea Pease
Phone: 972-548-4732
Fax:
E-mail: apease@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

IMM/LOCALS Program Leader: Torres Johnson
Phone: 972-548-5549
Fax:
E-mail: tmjohnson@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD #130, MCKINNEY, TX 75069

IMM/LOCALS Coordinator: Taylor Burton
Phone: 972-548-4464
Fax:
E-mail: tburton@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD #130, MCKINNEY, TX 75069

Authorized Signatory for DocuSign Chris Hill
Phone: 972-548-4623
Fax:
E-mail: chill@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Additional Authorized Signatory for DocuSign only if applicable (FFATA, Certs, etc) Andrea Pease
Phone: 972-548-4732
Fax:
E-mail: apease@co.collin.tx.us

DocuSign "CC" Person Christian Jimenez
Phone: 972-548-5619
Fax:
E-mail: cjimenez@co.collin.tx.us

Emergency Contact Taylor Burton
Cell Phone: 214-973-2023
Fax:
E-mail: tburton@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD #130, MCKINNEY, TX 75069

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 located 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	\$234,960	\$234,960	\$0	\$0	\$0	\$0
B. Fringe Benefits	\$115,464	\$115,464	\$0	\$0	\$0	\$0
C. Travel	\$1,828	\$1,828	\$0	\$0	\$0	\$0
D. Equipment	\$0	\$0	\$0	\$0	\$0	\$0
E. Supplies	\$1,810	\$1,810	\$0	\$0	\$0	\$0
F. Contractual	\$0	\$0	\$0	\$0	\$0	\$0
G. Other	\$0	\$0	\$0	\$0	\$0	\$0
H. Total Direct Costs	\$354,062	\$354,062	\$0	\$0	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$354,062	\$354,062	\$0	\$0	\$0	\$0
K. Program Income - Projected Earnings	\$25,390	\$25,390				

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 Category	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	Personnel	\$234,960	\$234,960	Fringe Benefits	\$115,464	\$115,464
	Travel	\$1,828	\$1,828	Equipment	\$0	\$0
	Supplies	\$1,810	\$1,810	Contractual	\$0	\$0
	Other	\$0	\$0	Indirect Costs	\$0	\$0

TOTAL FOR:	Distribution Totals	\$354,062	Budget Total	\$354,062
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*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
Registered Nurse (RN) - Program Manager - E (Position ID: 201271)	N	Provides program oversight & QA	0.45	RN License	\$7,505.00	12	\$40,527
Nurse (LVN) - E (Position ID: 201264)	N	Provides Imm Svcs, Outreach, audits	0.35	LVN License	\$5,365.00	12	\$22,533
Nurse (LVN) - E (Position ID: 201770)	Y	Provides Imm Svcs, Outreach, audits	0.35	LVN License	\$3,732.00	12	\$15,674
Registered Nurse (RN) - E (Position ID: 201274)	N	Provides Imm Svcs, Outreach, audits	0.35	RN License	\$7,059.00	12	\$29,648
Registered Nurse (RN) - E (Position ID: 201475)	N	Provides Imm Svcs, Outreach, audits	0.35	RN License	\$6,123.00	12	\$25,717
Outreach Specialist - E (Position ID: 300004)	N	Provides ImmTrac Svcs & Provider Ed.	0.35	NA	\$2,887.00	12	\$12,125
Immunization Service Aid - E (Position ID: 200950)	N	Provides ImmTrac Svcs & VFC Back Up	0.35	NA	\$3,017.00	12	\$12,671
Community Health Specialist - E (Position ID: 300456)	N	Provides Vaccine Inventory, Accountability & Provider QA	0.35	NA	\$4,584.00	12	\$19,253
Tech I - E (Position ID: 201467)	N	Provides Immunization Cler. Sup	0.35	NA	\$2,752.00	12	\$11,558
Outreach Specialist - E (Position ID: 300005)	N	Provides Immunization Cler. Sup	0.35	NA	\$2,887.00	12	\$12,125
Health Care Analyst - E (Position ID: 300214)	N	Perinatal Hep B & Epidemiology	0.35	NA	\$5,647.00	12	\$23,717
Healthcare Coordinator - E (Position ID: 200936)	N	Provides Prog. Planning & Evaluation	0.10	NA	\$7,843.00	12	\$9,412
							\$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							\$0
						SalaryWage Total	\$234,960

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.
	Fringe Benefit Rate %
	49.14%

	Fringe Benefits Total	\$115,464
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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:		Travel Costs												
			Days/Employees														
					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Mileage</td><td></td></tr> <tr><td>Airfare</td><td></td></tr> <tr><td>Meals</td><td></td></tr> <tr><td>Lodging</td><td></td></tr> <tr><td>Other Costs</td><td></td></tr> <tr><td style="text-align: right;">Total</td><td style="text-align: right;">\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		Total	\$0
Mileage																	
Airfare																	
Meals																	
Lodging																	
Other Costs																	
Total	\$0																
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Meals																	
Lodging																	
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Meals																	
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Mileage																	
Airfare																	
Meals																	
Lodging																	
Other Costs																	
Total	\$0																
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0												

Total for Conference / Workshop Travel

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Mileage reimbursement to schools, health care providers, daycares for outreach, audits and unannounced visits. Mileage for day travel (Arlington, ...)	2791	\$0.655	\$1,828		\$1,828
			\$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

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

Total Travel Costs:

Indicate Policy Used:

Respondent's Travel Policy

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
				\$0
				\$0
				\$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

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 <small>[If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]</small>	Purpose & Justification	Total Cost
Medical Supplies: Syringes (\$470/unit x 2)	Medical supplies for immunization clinic services	\$940
Medical Supplies: Alcohol Prep Pads (\$100/unit x 3)	Medical supplies for immunization clinic services	\$300
Medical Supplies: Bandages (\$190/unit x 3)	Medical supplies for immunization clinic services	\$570
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Supplies:

\$1,810

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
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL: \$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.

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 labeled Form I - 1 Personnel) have been used, go to the supplemental template labeled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labeled "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	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
Functional Title + Code E = Existing or P = Proposed							
							\$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

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
			\$0		\$0

Total for Other / Local Travel

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

Total Travel Costs:

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

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-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
						\$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
						\$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 - 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.