



FY2022

Contract Type: CPS/MRC-ASPR STTRONG

Applicant Information

Legal Name of Applicant Agency:
Mailing Address:

COLLIN COUNTY

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):
DUNS # (9 digits required for subrecipient contractors):

17560008736026
S1ETLA9BNCC5

Type of Entity (Choose one)

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

Project Period

Start Date: UPON EXECUTION
End Date: 5/30/2025

Counties Served

County(ies) Served:

COLLIN COUNTY

Amount of Funding Allocated:

\$47,242.00

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

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD ST #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

PHEP (HAZARDS) Program Leader: Meredith Nurge
Phone: 972-548-4708
Fax:
E-mail: mnurge@co.collin.tx.us

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

SNS (CRI) Coordinator: Amy Davis
Phone: 972-548-4473
Fax:
E-mail: aldavis@co.collin.tx.us

Mailing Address (street, city, county, state, & zip):
825 N. MCDONALD ST #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 Eric Dickey
Phone: 972-548-5696
Fax:
E-mail: edickey@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 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 (5)	Other Funds (6)
A. Personnel	\$30,620	\$30,620				
B. Fringe Benefits	\$14,138	\$14,138				
C. Travel	\$2,124	\$2,124				
D. Equipment	\$0	\$0				
E. Supplies	\$0	\$0				
F. Contractual	\$0	\$0				
G. Other	\$360	\$360				
H. Total Direct Costs	\$47,242	\$47,242				
I. Indirect Costs	\$0	\$0				
J. Total (Sum of H and I)	\$47,242	\$47,242				

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		
MRC Workshop	Required contractor meeting conducted by DSHS	Austin, TX	2 days/ 1 employee	Mileage	\$150
				Airfare	\$600
				Meals	\$150
				Lodging	\$500
				Other Costs	\$200
				Total	\$1,600
				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

\$1,600

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.	800	\$0.655	\$524		\$524
			\$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

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
						\$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 <small>Include quantity and cost/quantity</small>	Purpose & Justification	Total Cost
Cell Phone Service Plan x 1 employee for 6 months; \$55 per month	Cell phone voice and data service plan to be used by health department staff using their cell phones to communicate with stakeholders, providers, and others regarding public health activities	\$330
1x Cell Phone Internet Hotspot (\$5/month x 1 users x 6 months = \$30)	Mobile hotspot on cell phones for connecting to the internet in the field and for remote work.	\$30
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$360

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

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

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

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
						\$0

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

