

Budget Instructions by Category

Face Page

Legal Name	Full legal name is required (no abbreviations). Check past contracts to verify this is correct.
Mailing Address:	Include the full mailing address.
Payee Name:	Name of the person or entity where payments will be sent/received.
Payee Mailing Address:	Include the full payee mailing address.
State of Texas Comptroller Vendor ID # (9 digit + 3 digit mail code):	DSHS assigns this number. The TIN and MAIL CODE are both requirement.
Unique Entity Identifier (UEI)	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.
Type of Entity (Choose one)	A entity type must be checked.
Counties Served	Counties must be listed.
Amount of Funding Allocated	The funding amount should match the total allocation on the budget summary page.

Contact Page

Point of Contacts (POCs)	Add a point of contact as applicable for each category on the contact page.
Authorized Signatory	This contact is require and should be the person who signs the contract.
Additional Authorized Signatory	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..
DocuSign CC	This contact is not required, but contractors can include a cc person to be notified when the contracts are sent out via DocuSign.
Emergency Contact	This contact is required.

Budget Summary

Funding Categories	The summary must reflect the correct funding for each category. This information automatically rolls over from the individual category tabs.
---------------------------	--

Travel

Conference & Workshops	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 description. Travel costs must be as accurate at possible and a reasonable amount.
Mileage Only	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 they choose to use their internal policy, a copy is required.
Policy	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

Name and Functional Title	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.
Vacant	Must choose Yes or No.
Job Summary	This section must include a clear and accurate job summary for each employee.
FTEs	An FTE must be included. No one person can have more than 1 FTE.
Certifications & License	This section should list any required certificates or licenses. If none are required, it should be marked with an N/A.
Estimated Monthly Wage	The estimated monthly wage is required for each staff listed.
Number of Months	The number of months are required for each staff listed.
Salary/Wages	The FTE - Monthly Salary Wage -Number of Month make up the salary amount for each staff.

Fringe	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 project) to the extent that the benefits are reasonable and are incurred under formally established and consistently applied policies of the organization.
Equipment	
Description of Items	A description of items is required.
Purpose & Justification	A justification is required.
Number of Units	Required
Cost Per Unit	Required
Total Cost	The total cost must include a combined total for all units being purchased.
Equipment	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	
Description of Items	A detailed description of items is required.
Purpose & Justification	A detailed justification is required.
Total Cost	Required
The "Supplies" budget category is comprised of the following two separate and distinct components:	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	
Contractor Name	Required
Description of Services	A detailed description of items is required.
Justification	A detailed justification is required.
Method of Payment	Required
Number of Payments	Required
Rate of Payment	Required
Total Cost	Required
Contractual	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 party (subrecipient contracts)
Other	
Description of Items	A detailed description of items is required.
Purpose & Justification	A detailed justification is required.
Total Cost	Required
Other	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 treatment as "Other" (direct) or indirect must be consistent throughout the organization.
Indirect	

Indirect costs are those costs incurred for a common or joint purpose benefiting more than one cost objective (i.e., DSHS Program Attachment) and not readily assignable to the cost objectives specifically benefitted. Because of the diverse characteristics and accounting practices of organizations, it is not possible to specify the types of cost that may be classified as indirect cost in all situations. However, typical examples of indirect costs may include central service costs of a governmental unit; general administration and general expenses such as salaries and expenses of executive officers, personnel administration, accounting, and contracted administrative services; depreciation or use allowances on buildings and equipment; and the costs of operating and maintaining facilities, etc.



FY2025

Contract Type: CPS/CRI

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):

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: **7/1/2024**
End Date: **6/30/2025**

Counties Served

County(ies) Served: **COLLIN COUNTY**

Amount of Funding Allocated:

\$162,786.00

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
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 (Match) (5)	Other Funds (6)
A. Personnel	\$97,901	\$93,660			\$4,241	
B. Fringe Benefits	\$38,983	\$37,285			\$1,698	
C. Travel	\$16,140	\$16,140			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$9,875	\$9,875			\$0	
F. Contractual	\$0	\$0			\$0	
G. Other	\$16,115	\$5,780			\$10,335	
H. Total Direct Costs	\$179,014	\$162,740	\$0	\$0	\$16,274	\$0
I. Indirect Costs	\$0	\$0				
J. Total (Sum of H and I)	\$179,014	\$162,740	\$0	\$0	\$16,274	\$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	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
Name + Functional Title							
Aubrey Saylor, PHEP Planner	N	Performs PHEP activities to include supporting planning needs, partnering with stakeholders, and other grant functions	0.05	NA	\$8,100	12	\$4,860
Amy Davis, PHEP Planner	N	Performs PHEP activities to include supporting planning needs, partnering with stakeholders, and other grant functions	1.00	NA	\$7,400	12	\$88,800
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS							\$0
						SalaryWage Total	\$93,660

FRINGE BENEFITS	Itemize the elements of fringe benefits in the space below:						
FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums (\$1,500 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 0.1), Unemployment Insurance (salary x 0.001). Per life insurance HR, the calculation should be employees salary x 1.5 and then multiplied by 0.085 to include AD&D.							
Total Number of FTEs:	1.05			Fringe Benefit Rate %			39.81%
						Fringe Benefits Total	\$37,285

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		
NACCHO Preparedness Summit	Conference for public health and emergency preparedness professionals	Atlanta, GA	6 days/1 employees	Mileage	\$150
				Airfare	\$1,000
				Meals	\$800
				Lodging	\$2,000
				Other Costs	\$200
				Total	\$4,150
DSHS SNS Training or similar	TBD	TBD	3 Days/1 employee	Mileage	\$600
				Airfare	\$0
				Meals	\$600
				Lodging	\$1,000
				Other Costs	\$200
				Total	\$2,400
Texas Emergency Management Conference	Conference for public health and emergency preparedness professionals	Ft. Worth, TX	6 days/1 employees	Mileage	\$500
				Airfare	\$0
				Meals	\$700
				Lodging	\$2,000
				Other Costs	\$250
				Total	\$3,450
Southeast Texas Regional Advisory Council (SETRAC) Conference	Conference for public health and emergency preparedness professionals	Galveston, TX	5 Days/1 employee	Mileage	\$600
				Airfare	\$1,000
				Meals	\$800
				Lodging	\$2,000
				Other Costs	\$400
				Total	\$4,800
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0

Total for Conference / Workshop Travel

\$14,800

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 PHEP funded staff.	2000	\$0.670	\$1,340		\$1,340
			\$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 \$1,340

Other / Local Travel Costs: \$1,340

Conference / Workshop Travel Costs: \$14,800

Total Travel Costs: \$16,140

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

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
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 <small>Provide estimated quantity and cost</small>	Purpose & Justification	Total Cost
<p>POD Supplies - These include additional 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, prophylaxis, etc., as needed to support various deliverables, including Mass Prophylaxis operations and dispensing models other than open PODs, emergency prophylaxis for outbreaks and events (i.e. Ciprofloxacin, Doxycycline, Amoxicillin; Emergency Prophylaxis will only be purchased for first responders). Walkie Talkies for communication between PHEP team for drills and exercises, also used for emergencies for efficient communication, especially if powerlines are down. Designated reflective safety vests for Medical Reserve Corps members, to be worn at POD sites (drive-thru, outdoor or indoor location), real world events, or exercises and drills. Reflective safety vests will identify roles and specific skillset of volunteers at POD site locations or MRC events, as well as distinguish volunteers from public health emergency preparedness staff.</p>	<p>Various supplies for deployable POD kits.</p>	<p>\$2,500</p>

Grant Program Supplies	Program supplies that are vital to the program and emergency response. These items include, but are not limited to, preparedness kits, vehicle emergency kits, CPR masks, electronic device chargers, first aid kits, bleeding control kits, bags to hold documents, insect repellent, and coloring puzzle books.	\$1,075
Office Supplies	Clipboards, paper, writing utensils, labels, folders, binders, etc...to produce reports, documentation, and support grant functions.	\$300
Medication Counting Machine	Devices that will be used to prepare emergency prophylaxis for Strategic National Stockpile activations and other public health emergencies that involve medical countermeasures (\$3,000/unit x 2).	\$6,000
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Supplies:

\$9,875

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
Conference Registration Fees	Registration fees for: NACCHO Preparedness Summit \$850 X 1, Collin County Mental Health Symposium \$125 x2, Texas Emergency Management Conference \$700 x 1, SETRAC x 1 \$400 or other TBD local conference fees relevant to the program.	\$2,200
Cell Phone Service Plan x 1 employees for 12 months; \$60 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	\$720
1x Cell Phone Internet Hotspot (\$5/month x 1 users x 12 months) = \$60	Mobile hotspot on cell phones for connecting to the internet in the field and for remote work.	\$60
Certifications and Staff Training	Staff to be trained on HIPAA, Blood Borne Pathogens, Sexual Harassment, Cultural Competency, De-Escalation, continuing education, naloxone, CPR and any other applicable trainings that improve healthcare interactions with patients.	\$2,500
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.	\$300

	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	\$0

Total Amount Requested for Other:

\$5,780

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

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

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

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

Total Amount Requested for Equipment:

\$0

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
				\$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 <small>[if applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]</small>	Purpose & Justification	Total Cost

Total Amount Requested for Supplies:

\$0

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 <small>[if applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]</small>	Purpose & Justification	Total Cost

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
						\$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
						\$0

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

OTHER COSTS Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

COLLIN COUNTY

Description of Item <small>[If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]</small>	Purpose & Justification	Total Cost

Total Amount Requested for Other:

\$0

OTHER COSTS Budget Category Detail Form (Match)

Legal Name of Respondent:

COLLIN COUNTY

Description of Item <small>[If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]</small>	Purpose & Justification	Total Cost
MATCH - Volunteer Activities	MRC volunteer training and events participation (31.80/hour - calculated from Independent Sector for 325 hours of service.	\$10,335

Total Amount Requested for Other:

\$10,335