



FY2022

Contract Type: CPS/PHIG (Year 5)

Applicant Information

**Legal Name of Applicant Agency:
Mailing Address:**

Collin County

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 funds)

S1ETLA9BNCC5

Type of Entity (Choose one)

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

Project Period

Start Date: 12/1/2026
End Date: 11/30/2027

Counties Served

County(ies) Served:

Collin

Amount of Funding Allocated:

\$1,625,736.00

CONTACT PERSON INFORMATION

Legal Business Name:

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
Phone: Ext:
Fax:
E-mail:

Mailing Address (street, city, county, state, & zip):

B-13/FSR Rep:
Phone: Ext:
Fax:
E-mail:

Mailing Address (street, city, county, state, & zip):

PHEP (HAZARDS) Program Leader:
Phone: Ext:
Fax:
E-mail:

Mailing Address (street, city, county, state, & zip):

SNS (CRI) Coordinator:
Phone: Ext:
Fax:
E-mail:

Mailing Address (street, city, county, state, & zip):

Authorized Signatory for **DocuSign**
Phone: Ext:
Fax:
E-mail:

Mailing Address (street, city, county, state, & zip):

Additional Authorized Signatory for **DocuSign only if applicable (FFATA, Certs, etc)**
Phone: Ext:
Fax:
E-mail:

DocuSign "CC" Person
Phone: Ext:
Fax:
E-mail:

Emergency Contact
Cell Phone: Ext:
Fax:
E-mail:

Mailing Address (street, city, county, state, & zip):

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	\$230,440	\$230,440				
B. Fringe Benefits	\$101,026	\$101,026				
C. Travel	\$875	\$875				
D. Equipment	\$0	\$0				
E. Supplies	\$200	\$200				
F. Contractual	\$0	\$0				
G. Other	\$1,980	\$1,980				
H. Total Direct Costs	\$334,521	\$334,521				
I. Indirect Costs	\$0	\$0				
J. Total (Sum of H and I)	\$334,521	\$334,521				

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		
				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

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Local travel reimbursement for grant staff for out of office meetings, seminars, exercises, training, including day travel within the Dallas-Fort Worth metropolitan area. (Note: Internal Revenue Service standard mileage rate applies.)	1306	\$0.670	\$875		\$875
			\$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

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; Position ID: 300516)	N	Assists with grant performance goals and deliverables; supports grant functions and special projects as needed	1.00	NA	\$9,366	6	\$56,194.00
Health Care Analyst (Bethany MacDonald; Position ID: 300527)	N	Provides administrative support for Epidemiology, Immunizations, and other Health Care programs	1.00	NA	\$6,214	6	\$37,285.00
Functional Analyst (Tina Dunn; Position ID: 300517)	N	Assists with management of departmental databases, software, and reporting; Identifies areas for improvement and supports information system projects	1.00	NA	\$7,824	6	\$46,944.00
Functional Analyst (Patrick Hill; Position ID: 300621)	N	Assists with management of departmental databases, software, and reporting; Identifies areas for improvement and supports information system projects	1.00	NA	\$7,225	6	\$43,348.00
Financial Analyst (Eric Dickey; Position ID: 300526)	N	Assists with grant performance goals and deliverables; supports grant functions and special projects as needed	1.00	NA	\$7,778	6	\$46,669.00
							\$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	\$230,440

FRINGE BENEFITS		Itemize the elements of fringe benefits in the space below:	
a. Fringe Benefits: FICA/Medicare (salary x 0.0765), Insurance Premiums (\$1,500 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 0.10), 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:	5.00	Fringe Benefit Rate %	43.84%
		Fringe Benefits Total	\$101,026

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
				\$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
Office Supplies	Consumable general office supplies for grant staff to include clipboards, paper, writing utensils, labels, folders, binders, paper clips, sticky notes, etc. to produce reports, documentation, and support grant functions. (No one item shall exceed \$499)	\$100
Computer Supplies	HDMI cables, adapters, mousepads, extension cords, wireless mouse, headsets, and other computer supplies as needed. (No one item shall exceed \$499)	\$100
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Supplies:

\$200

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 Plans (\$45/month per staff; \$45 x 6 months x 2 staff = \$540)	Cell phone voice and data plans to be used by grant staff in order to communicate with stakeholders, providers, and others regarding public health activities	\$540
MiFi Device Service Plan (\$40/month x 2 staff x 6 months) = \$480	MiFi device service plan to be used by staff with their cell phone and/or laptop to access the county network, internet, and other software for program activities	\$480
Certifications and Staff Training	Trainings for grant staff on HIPAA (\$30/unit x 5), Blood Borne Pathogens (\$30/unit x 5), Sexual Harrassment (\$20/unit x 5), Cultural Competency (\$60/unit x 5), CPR certification (\$30/unit x 5), Saf-T Pak Certification (\$110/unit x 1), or similar staff trainings	\$960
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$1,980

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
			\$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
				\$0

Total Amount Requested for Equipment:

\$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

