



**FY25- TB FED  
TB/PC FED**

**Applicant Information**

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

Collin County

Street / PO Box: 825 N. McDonald #130  
City: McKinney  
Zip: 75069

**Payee Name:**

Collin County

**Payee Mailing Address:**

Street / PO Box: 825 N. McDonald #130  
City: McKinney  
Zip: 75069

**State of Texas Comptroller Vendor ID #** (11 digit + 3 digit mail code):

17560008736000

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

S1ETLA9BNCC5 (Unique ID)

**Fiscal Year-End Date (MM/DD)**

08/31

**Type of Entity (Choose one)**

- City:  Click on appropriate box  
 County:   
 Other Political Subdivision:   
 Nonprofit Organization:   
 Community-Based Organization:   
 Hospital:   
 State Controlled Institution of Higher Learning:   
 Other:   
 Faith Based (Nonprofit Org):

**Contract Term:**

Start Date: 9/1/2024  
End Date: 8/31/2025

**State-wide or Counties Served**

State-wide or County(ies) Served:

Collin

**Amount of Funding Allocated:**

\$84,572.00

CONTACT PERSON INFORMATION

Legal Business Name: Collin County

This form provides information about the appropriate contacts in the contractor's organization. If any of the following information changes during the term of the contract, please send written/e-mail notification to the Assigned Contract Manager.

Health Director / CEO / Executive Director: Candy Blair
Direct Phone: 972-548-5504
E-mail: cblair@co.collin.tx.us

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

B-13 Submitter: Andrea Pease
Direct Phone: 972-548-4732
E-mail: apease@co.collin.tx.us

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

Program Lead Person: Candice Akins
Direct Phone: 972-548-5509
E-mail: cakins@co.collin.tx.us

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

Contract Lead Person: Taylor Burton
Direct Phone: 972-548-4464
E-mail: tburton@co.collin.tx.us

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

Contract Authorized Signatory: Chris Hill
Direct Phone: 972-548-4632
E-mail: chill@co.collin.tx.us

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

Additional Contract Authorized Signatory
Direct Phone:
E-mail:

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

FFATA/Assurances Signatory: Andrea Pease
Direct Phone: 972-548-4732

Mailing Address (street, city, county, & 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 (Match) (5)	Other Funds (6)
A. Personnel	\$68,885	\$57,265			\$11,620	
B. Fringe Benefits	\$30,350	\$25,056			\$5,294	
C. Travel	\$1,187	\$1,187			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$1,064	\$1,064			\$0	
F. Contractual	\$0	\$0			\$0	
G. Other	\$0	\$0			\$0	
H. Total Direct Costs	\$101,486	\$84,572	\$0	\$0	\$16,914	\$0
I. Indirect Costs	\$0	\$0				
J. Total (Sum of H and I)	\$101,486	\$84,572	\$0	\$0	\$16,914	\$0
				<b>Match Percentage</b>	<b>20.00%</b>	

### PERSONNEL Budget Category Detail Form

Legal Name of Respondent:

Collin County

PERSONNEL	Vacant Y/N	Job Summary	FTEs	Certification or License <small>(Enter NA if not required)</small>	Estimated Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Name + Functional Title							
Dawn West - Registered Nurse (RN) <small>(Position ID: 300161)</small>	N	Provides TB case management services as a registered nurse	0.39	License	\$7,897	12	\$36,958
Cynthia Leung - Medical Assistant <small>(Position ID: 300176)</small>	N	Serves as TB case registrar, performing TB data collection and reporting duties	0.39	N/A	\$4,339	12	\$20,307
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
<b>TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS</b>							\$0

	<b>SalaryWage Total</b>	\$57,265
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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.			
<b>Total Number of FTEs:</b>	<b>0.78</b>		<b>Fringe Benefit Rate %</b> 43.75%
		<b>Fringe Benefits Total</b>	<b>\$25,056</b>

## 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	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	\$0
				Airfare	\$0
				Meals	\$0
				Lodging	\$0
				Other Costs	\$0
				<b>Total</b>	\$0
				Mileage	\$0
				Airfare	\$0
				Meals	\$0
				Lodging	\$0
				Other Costs	\$0
				<b>Total</b>	\$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 mileage reimbursement for the following staff (Dawn West (RN); ID: 300161, Cynthia Leung (Medical Assistant); ID: 300176 , Elvia Priest (TB	1025	\$0.670	\$687		\$687
Local travel for the following staff (Dawn West (RN); ID: 300161, Cynthia Leung (Medical Assistant); ID: 300176 , Elvia Priest (TB Outreach Worker); ID:	746	\$0.670	\$500		\$500
			\$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

## 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
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
Medical Supplies: Personel Protection Equipment (PPE) masks estimated \$30/unit x 5	Protection equipment masks for TB program use (Face covering, N95, etc.) (Note: Supplies will not be purchased before 01/01/2025)	\$150
Medical Supplies: Alcohol Prep Wipes est. cost (\$80/unit x 1)	Supplies for TB program medical supply needs (Note: Supplies will not be purchased before 01/01/2025)	\$80
Medical Supplies: Ancillary Supplies/Needles \$88/unit x 3	Needles for TB program medical supply needs (Note: Supplies will not be purchased before 01/01/2025)	\$264
Medical Supplies: Biohazard Specimen Bags \$25/unit x 6	Bags to remove biohazardous waste related to TB program (Note: Supplies will not be purchased before 01/01/2025)	\$150
Medical Supplies: Procedure Towels \$40/unit x 2	Supplies for TB program medical supply needs (Note: Supplies will not be purchased before 01/01/2025)	\$80
Medical Supplies: Tourniquets \$25/unit x 4	Supplies for TB program medical supply needs (Note: Supplies will not be purchased before 01/01/2025)	\$100
Medical Supplies: Phlebotomy Grips \$100/unit x1	Supplies for TB program medical supply needs (Note: Supplies will not be purchased before 01/01/2025)	\$100
Medical Supplies: Fingertip Pulse Oximeter \$100/unit x 1	Supplies for TB program medical supply needs (Note: Supplies will not be purchased before 01/01/2025)	\$100
Program Supplies: Variety of Small Toys (Rubber ducks, stress balls, finger puppets, etc.) estimated cost \$40 per case unit x 1	Small gift items that would be used as patient incentives for TB pediatric patients such as finger puppets, rubber duckies, etc. (Note: Supplies will not be purchased before 01/01/2025)	\$40
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		



Total Amount Requested for Supplies:

**\$1,064**

## 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
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: \$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 (Indirect Costs)**

<b>RATE:</b>	<b>EXAMPLE</b> 8.75%
<b>BASE:</b>	<b>EXAMPLE</b> - Modified total direct, including subgrants and subcontracts up to the first \$25,000; excluding equipment, capital equipment, as well as the portion of each subgrant and subcontract in excess of \$25,000.00.

**INSTRUCTIONS:** Organizations that have an approved indirect cost rate should complete the section above by marking the box and indicating the rate and base. A copy of the approved rate agreement that will be in effect during the contract term should be submitted with the Budget Templates. If a rate agreement is pending, submit the latest approved agreement.

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 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

**PERSONNEL Budget Category Detail Form (Supplemental)**

Legal Name of Respondent:

Collin County

<b>PERSONNEL</b>							
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
							\$0
							\$0
							\$0
			0.00				
					<b>SalaryWage Total</b>		<b>\$0</b>

**PERSONNEL Budget Category Detail Form (Match)**

Legal Name of Respondent:

Collin County

<b>PERSONNEL</b>							
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
Elva Priest - TB Outreach (ID: 201476)	N	Provides DOT to TB Patients	0.16	N/A	\$6,052	12	\$11,620
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
						<b>SalaryWage Total</b>	<b>\$11,620</b>

<b>FRINGE BENEFITS</b>		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.		
		Fringe Benefit Rate %
		45.56%
		Fringe Benefits Total
		\$5,294

## 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	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$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	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$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
				\$0
				\$0

Total Amount Requested for Equipment:

<b>\$0</b>
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## 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
				\$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

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 &amp; cost/box)]</small>	Purpose & Justification	Total Cost

Total Amount Requested for Supplies:

<b>\$0</b>
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## 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
						\$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

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 &amp; cost/unit)]</small>	Purpose & Justification	Total Cost

Total Amount Requested for Other:

**\$0**

## OTHER COSTS Budget Category Detail Form (Match)

Legal Name of Respondent:

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

Total Amount Requested for Other:

	<b>\$0</b>
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