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	$660,606.92	$660,606.92	$0	$0		$0
B. Fringe Benefits	$253,564.02	$253,564.02	$0	$0		$0
C. Travel	$5,156.00	$5,156.00	$0	$0		$0
D. Equipment	$0.00	$0.00	$0	$0		$0
E. Supplies	$45,702.24	$45,702.24	$0	$0		$0
F. Contractual	$0.00	$0.00	$0	$0		$0
G. Other	$33,079.82	$33,079.82	$0	$0		$0
H. Total Direct Costs	$998,109.00	$998,109.00	$0	$0		$0
I. Indirect Costs	$0.00	$0.00	$0	$0		$0
J. Total (Sum of H and I)	$998,109.00	$998,109.00	$0	$0		$0
K. Program Income - Projected Earnings	$0	$0				

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 Catetory	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	**Personnel**	**$660,606.92**	**$660,606.92**	**Fringe Benefits**	**$253,564.02**	**$253,564.02**
	Travel	**$5,156.00**	**$5,156.00**	**Equipment**	**$0.00**	**$0.00**
	Supplies	**$45,702.24**	**$45,702.24**	**Contractual**	**$0.00**	**$0.00**
	Other	**$33,079.82**	**$33,079.82**	**Indirect Costs**	**$0.00**	**$0.00**

TOTAL FOR:	**Distribution Totals**	**$998,109.00**	**Budget Total**	**$998,109.00**

*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
Epidemiologist (EX2) - Alia Soliman (Position ID: 300490)	N	Performs COVID-19 disease investigations, public health follow up, surveillance and reporting activities	1.00	NA	$6,575.46	46	$302,471.16
Epidemiologist (EX2) - Obiageli Anitube (Position ID: 300471)	N	Performs COVID-19 disease investigations, public health follow up, surveillance and reporting activities	1.00	NA	$6,490.25	28	$181,727.00
Epidemiologist (EX2) - Discontinued	N	Performs COVID-19 disease investigations, public health follow up, surveillance and reporting activities	1.00	NA	$5,726.57	14	$80,171.98
Epidemiologist (EX2) - Discontinued	N	Performs COVID-19 disease investigations, public health follow up, surveillance and reporting activities	1.00	NA	$5,150.48	5	$25,752.40
Epidemiologist (EX2) - Discontinued	N	Performs COVID-19 disease investigations, public health follow up, surveillance and reporting activities	1.00	NA	$5,533.70	12	$66,404.38
Internship (EX2) - Discontinued	N	Provides administrative support for Epidemiologist	1.00	NA	$680.00	6	$4,080.00
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$660,606.92

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.

Fringe Benefit Rate %	38.38%
Fringe Benefits Total	$253,564.02

Revised: 7/6/2009

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: Days/Employees	Travel Costs	
DSHS Epidemiology Training 2025 (EX1)	DSHS Training Workshop for Epidemiology professionals	Austin, TX	4 Days / 1 Staff	Mileage	$400
				Airfare	$0
				Meals	$178
				Lodging	$900
				Other Costs	$100
				Total	$1,578
DSHS Epidemiology Training 2026 (EX1)	DSHS Training Workshop for Epidemiology professionals	Austin, TX	4 Days / 1 Staff	Mileage	$400
				Airfare	$0
				Meals	$178
				Lodging	$900
				Other Costs	$100
				Total	$1,578
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Revised: 7/6/2009

Total for Conference / Workshop Travel $3,156

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Attend meetings, seminars, exercises, training, including all day travel within DFW metroplex will be utilized by all staff performing required trainings and grant duties. (EX1) (Note: Internal Revenue Service standard mileage rate utilized; while IRS rate may	1493	$0.670	$1,000.00		$1,000.00
On-site visits to conduct public followup activities, enhance data and surveillance, provide guidance/education to mitigate the spread of COVID-	1493	$0.670	$1,000.00		$1,000.00
			$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 $2,000.00

Other / Local Travel Costs: $2,000 **Conference / Workshop Travel Costs:** $3,156 **Total Travel Costs:** **$5,156.00**

Revised: 7/6/2009

Indicate Policy Used:	Respondent's Travel Policy	Yes	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
TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS				$0

Total Amount Requested for Equipment: **$0.00**

Revised: 7/6/2009

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 [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
Computer-Tablets x 2 including docking station, key board, stylus, mouse, and three monitors ; $2729.52 each; For (1) Epidemiologist, Internship (EX1)	Computers to used by health department staff for disease investigations, creating documentation, analyzing data, and other public health activities	$5,459.04
Desk Phones x 2 to include phone maintenance fees; $160.14 ea; For (1) Epidemiologist, Internship (EX1)	Desk phones to be used by health department staff to communicate with stakeholders, providers and others regarding disease investigations	$320.28
Scanner - Top Feed x 2; county standard desktop scanner; $1088 ea; For (1) Epidemiologist, Internship (EX1)	Scanners to be used by staff to produce electronic files for retention of disease investigation reports and related documents	$1,558.00
Printer-Color-Medium with additional paper tray x 1; $579.92 each printer, $256.47 each tray; For (1) Epidemiologist (EX1)	Printers to be used by staff to produce grant related documents	$836.39
4x Workstation Desk Package for staff; $1407.77 each; for (3) Epidemiologists, Internship (EX1)	Cost for necessary furniture required due to new positions resulting from expanded workforce.	$5,631.08
Supplies for Testing and Transport of Specimens (EX3)	Biohazard bags and shipping boxes, swabs, COVID-19 testing kits, and other supplies to support health department for providing disease testing to patients and/or public.	$30,867.45
Office Supplies (EX1)	Consumable general office supplies for grant staff to include clipboards, paper, writing utensils, labels, folders, binders, paper cli	$750.00
Printed Materials (EX1)	Business cards for staff to conduct outreach and provide contact information during public health follow up activities ($70/unit x 2 staff x 2 years) (EX1)	$280.00
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$45,702.24**

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
None						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

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

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	Purpose & Justification	Total Cost
Adobe DC software licenses x2; cost $86.22 ea; (3) Epidemiologist, Internship (EX2)	Computer software to be used by health department staff to edit, combine, and sign electronic .pdf documents used in stakeholder outreach tasks.	$172.44
Software-EA licenses X 2 including Microsoft Office Suite; $589.88 ea.; (3) Epidemiologist, Internship (EX2)	Computer software to be used by health department staff to communicate by email, produce disease reports, enter and track disease surveillance data	$1,179.76
Software for building vaccine data collection system interfaces, data processing, and data visualizations - License type and quantity will vary (EX2)	Software examples may include licenses and maintenance fees for Laserfiche, Jotform, DocuSign, Tableau, ArcGIS, SQL, or other systems.	$27,288.00
Cell Phone Service Plan x 3, for X 2 years; annual cost of voice and data plan $576 ea; For (3) Epidemiologist (EX2)	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 disease investigations	$2,581.68
Printing and Communication Materials (E1F)	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.	$57.94
Cell Phone Service Plan with hotspot service add-on service x 2 staff, for 20 months; monthly cost of voice and data plan $45 each month each line; For (2) Epidemiologist (EX2); estimated total = $1800.00	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 disease investigations (No one item shall exceed $499)	$1,800.00
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Revised: 7/6/2009

Total Amount Requested for Other:	**$33,079.82**

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.	

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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 labled Form I - 1 Personnel) have been used, go to the supplemental template labled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labled "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 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

Revised: 7/6/2009

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

Revised: 7/6/2009

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
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0

Total for Conference / Workshop Travel $0

Revised: 7/6/2009

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**

Revised: 7/6/2009

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
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0

Total for Conference / Workshop Travel $0

Revised: 7/6/2009

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**

Revised: 7/6/2009

FORM I-3: EQUIPMENT 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**

FORM I-3: EQUIPMENT 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**

FORM I-4: SUPPLIES including CONTROLLED ASSETS 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**

Revised: 7/6/2009

FORM I-4: SUPPLIES including CONTROLLED ASSETS 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**

Revised: 7/6/2009

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

Total Amount Requested for CONTRACTUAL: $0

Revised: 7/6/2009

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

Total Amount Requested for CONTRACTUAL: $0

Revised: 7/6/2009

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**

Revised: 7/6/2009

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**

Revised: 7/6/2009

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.	

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