



FY2026
Contract Type: CPS/LRN-PHEP

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: 7/1/2025
End Date: 6/30/2026

Counties Served

County(ies) Served: COLLIN

Amount of Funding Allocated:

\$133,431.00

Revised 12/24

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 Ext:
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: Bethany MacDonald
Phone: 972-548-5520 Ext:
Fax:
E-mail: bmacdonald@co.collin.tx.us

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

825 N. MCDONALD ST #130, MCKINNEY, TX 75069

PHEP Program Leader: Meredith Nurge
Phone: 972-548-4708 Ext:
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: 972-548-4708 Ext:
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 Ext:
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: 972-548-4731 Ext:
Fax:
E-mail: apease@co.collin.tx.us

DocuSign Additional Routing Instructions

Additional Authorized Signatory completes the contract document fields, but does not sign any of the documents. Authorized Signatory signs on all documents.

DocuSign "CC" Person: Bethany MacDonald
Phone: 972-548-5520 Ext:
Fax:
E-mail: bmacdonald@co.collin.tx.us

Emergency Contact: Taylor Burton
Cell Phone: 214-973-2023 Ext:
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	\$87,331	\$82,549			\$4,782	
B. Fringe Benefits	\$36,091	\$34,195			\$1,896	
C. Travel	\$0	\$0			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$2,574	\$2,574			\$0	
F. Contractual	\$0	\$0			\$0	
G. Other	\$7,435	\$770			\$6,665	
H. Total Direct Costs	\$133,431	\$120,088	\$0	\$0	\$13,343	\$0
I. Indirect Costs	\$13,343	\$13,343				
J. Total (Sum of H and I)	\$146,774	\$133,431	\$0	\$0	\$13,343	\$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[illegible]

FRINGE BENEFITS		Itemize the elements of fringe benefits in the space below:		
FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums (\$1,700 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/month, Retirement (salary x 0.1), 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:	0.85		Fringe Benefit Rate %	41.42%
			Fringe Benefits Total	\$34,195

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	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				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

\$0
Revised 12/25/2014

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
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.

[illegible]

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 Provide estimated quantity and cost	Purpose & Justification	Total Cost
POD Signage & Drive thru Items : POD Signage inside and outside and drive-thru items (such as cones, stanchions, stanchion carts, safety lights, crowd control posts and small barriers) 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	Various supplies for deployable POD kits.	\$897
Grant Program Supplies: These items include, preparedness kits, vehicle emergency kits, CPR masks, electronic device chargers for emergency field activities during power outages, first aid kits, bleeding control kits, bags to hold documents	Program supplies that are vital to the program and emergency response for deployable POD kits and PHEP Team response.	\$500
MCM Supplies: Prophylaxis, 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). Also includes alpha or first responder POD planning not covered by POD supplies	Emergency prophylaxis for outbreaks and preparation for emergency response to catastrophic events. Will only be used by PHEP, individuals supporting the PHEP Team, POD or Emergency Response.	\$500

Replacement of Existing POD Supplies: replacement of existing expired POD supplies (such as hand sanitizer, hand held radios, batteries, bandages, scales, masks, PPE, storage containers and bags, training assets for drills, and gloves)	Various supplies for deployable POD kits.	\$500
POD Inventory & Administrative Supplies: administrative supplies for drive-thru PODs (such as enclosed clipboards), and POD inventory supplies (such as inventory marking tools and supplies, label maker tape, labels, cable ties, carabiners, file expanders, sheet protectors, writing utensils, clipboards, dividers, paper)	Various supplies for deployable POD kits and vital function of the program and emergency response. To produce reports, documentation and support grant functions.	\$177
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

\$2,574

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 Include quantity and cost/quantity	Purpose & Justification	Total Cost
Certifications and Staff Training (x1 employee, Amy Davis)	Staff to be trained on HIPAA, Blood Borne Pathogens, De-Escalation, naloxone, SAF-T-PAK and CPR.	\$770
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$770

Indirect Costs

Legal Name of Respondent:

COLLIN COUNTY

Total amount of indirect costs allocable to the project:

Amount:

\$13,343

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:

In the process of negotiating federal rate.

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.

x

RATE:

TYPE:

BASE:

Rate: 18.24%. Collin County is seeking a 10% de minimis rate on this grant.
Type: Indirect Cost Rate
Base: Wages & Benefits

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:

Please see attached.

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

PERSONNEL Budget Category Detail Form (Supplemental)

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
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
			0.00				
						SalaryWage Total	\$0

PERSONNEL Budget Category Detail Form (Match)

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							
MATCH - Andrea Pease, Accountant/Auditor	N	Completes FSRs and maintains fiscal auditing documentation	0.05	NA	\$7,970	12	\$4,782
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
						SalaryWage Total	\$4,782

FRINGE BENEFITS	Itemize the elements of fringe benefits in the space below:		
FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums (\$1,700 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/month, Retirement (salary x 0.1), 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.			
	<table> <tr> <td>Fringe Benefit Rate %</td><td>39.65%</td></tr> </table>	Fringe Benefit Rate %	39.65%
Fringe Benefit Rate %	39.65%		
	<table> <tr> <td>Fringe Benefits Total</td><td>\$1,896</td></tr> </table>	Fringe Benefits Total	\$1,896
Fringe Benefits Total	\$1,896		

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

Other / Local Travel Costs

Revised: 3/25/2014

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

Revised: 3/25/2014

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
				\$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 [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 [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	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

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 [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	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 [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost
MATCH - Volunteer Activities	MRC volunteer training and events participation (33.49/hour - calculated from Independent Sector for 200 hours of service.	\$6,665

Total Amount Requested for Other:

\$6,665