TEXAS Department of State Health Services

2026- 2027

Contract Type: RLSS/LPHS FY26/27

9/1/2025-8/31/2027

Applicant Information

Legal Name of Applicant Agency: Collin County

Mailing Address:

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

Payee Name:

Payee Mailing Address:

Street / PO Box:
City:
Zip:

State of Texas Comptroller Vendor ID # (9 digit + 3 digit mail code)**:** 75-6000873

UEI Code (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)

Click on appropriate box

City: ☐
County: ☑
Other Political Subdivision: ☐

Project Period

Start Date: 9/1/2025
End Date: 8/31/2026

Counties Served

County(ies) Served: Collin

Amount of Funding Allocated: $21,639.00

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: 972-548-4766 Ext: 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: Bethany MacDonald
Phone: 972-548-4766 Ext: 5520
Fax:
E-mail: bmacdonald@co.collin.tx.us
Mailing Address (street, city, county, state, & zip): 825 N. McDonald St. #130, McKinney TX 75069

RLHO Rep:
Phone: Ext:
Fax:
E-mail:
Mailing Address (street, city, county, state, & zip):

Additional Contact: Christian Jimenez
Phone: 972-548-4766 Ext: 5619
Fax:
E-mail: cjimenez@co.collin.tx.us
Mailing Address (street, city, county, state, & zip):

Authorized Signatory for **DocuSign**: Chris Hill
Phone: 972-548-4632 Ext:
Fax:
E-mail: chill@co.collin.tx.us
Mailing Address (street, city, county, state, & zip): 2300 Bloomdale Road, McKinney, TX 75071

Additional Authorized Signatory for **DocuSign only if applicable (FFATA, Certs, etc)**: Sharon Fitzwater
Phone: 972-548-4646 Ext:
Fax:
E-mail: sfitzwater@co.collin.tx.us

DocuSign "CC" Person (recieves a copy only.): Taylor Burton
Phone: 972-548-4766 Ext:
Fax:
E-mail: tburton@co.collin.tx.us

DocuSign "CC" Person (recieves a copy only.): Bethany MacDonald
Phone: 972-548-4766 Ext:
Fax:
E-mail: bmacdonald@co.collin.tx.us

Emergency Contact: Taylor Burton
Cell Phone: 972-548-4464 Ext:
Fax:
E-mail: tburton@co.collin.tx
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 (5)	Other Funds (6)
A. Personnel	$12,341	$12,341				
B. Fringe Benefits	$7,134	$7,134				
C. Travel	$0	$0				
D. Equipment	$0	$0				
E. Supplies	$0	$0				
F. Contractual	$0	$0				
G. Other	$0	$0				
H. Total Direct Costs	$19,475	$19,475				
I. Indirect Costs	$2,164	$2,164				
J. Total (Sum of H and I)	$21,639	$21,639				

NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts in whole dollars for (3), (4), & (6), *if applicable*. 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**	**$12,341**	**$12,341**	**Fringe Benefits**	**$7,134**	**$7,134**
	Travel	**$0**	**$0**	**Equipment**	**$0**	**$0**
	Supplies	**$0**	**$0**	**Contractual**	**$0**	**$0**
	Other	**$0**	**$0**	**Indirect Costs**	**$2,164**	**$2,164**

TOTAL FOR:	**Distribution Totals**	**$21,639**	**Budget Total**	**$21,639**

Revised: 04/14/2014

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	
				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
				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: 3/25/2014

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 $0

Other / Local Travel Costs: $0 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** **$0**

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

Revised: 3/25/2014

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
Cynthia Leung, Medical Assistant (Position ID: 300176) September 1, 2025 - August 31, 2026	N	Serves as TB case registrar, performing TB data collection and reporting duties	0.20	N/A	$5,142	12	$12,341
							$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		$12,341

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:	**0.20**		**Fringe Benefit Rate %**	57.81%
			Fringe Benefits Total	$7,134

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
TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS				$0

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

Revised: 3/25/2014

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**
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 3/25/2014

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
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 3/25/2014

OTHER COSTS Budget Category Detail Form

Legal Name of Respondent: Collin County

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 3/25/2014

Indirect Costs

Legal Name of Respondent:		**Collin County**
Total amount of indirect costs allocable to the project:	**Amount:**	**$2,164**

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

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
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0

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

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
				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

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

Revised: 3/25/2014

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**
		$0

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

Revised: 3/25/2014

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

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

Revised: 3/25/2014

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