TEXAS Department of State Health Services

FY26 IMM Locals

IMM/Locals

Applicant Information

Legal Name of Applicant Agency:	Collin County
Mailing Address:	
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 # (11 digit + 3 digit mail code):	17560008736 026
DUNS # (9 digits required for subrecipient contractors):	S1ETLA9BNCC5 (Unique Entity ID)
Fiscal Year-End Date (MM/DD)	08/31

Type of Entity (Choose one)

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

Contract Term:

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

State-wide or Counties Served

State-wide or County(ies) Served:	Collin
Amount of Funding Allocated:	$354,062.00

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			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-5504	Ext:		
Fax:				
E-mail:	cblair@co.collin.tx.us			825 N. MCDONALD #130, MCKINNEY, TX 75069
B-13/FSR Rep:	Christian Jimenez			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-5619	Ext:		
Fax:				
E-mail:	cjimenez@co.collin.tx.us			825 N. MCDONALD #130, MCKINNEY, TX 75069
IMM/LOCALS Program Leader:	Torres McNeal			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-5549	Ext:		
Fax:				
E-mail:	tmcneal@co.collin.tx.us			825 N. MCDONALD #130, MCKINNEY, TX 75069
IMM/LOCALS Coordinator:	Taylor Burton			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4464	Ext:		
Fax:				
E-mail:	tburton@co.collin.tx.us			825 N. MCDONALD #130, MCKINNEY, TX 75069
Authorized Signatory for **DocuSign**	Chris Hill			Mailing Address (street, city, county, state, & zip):
Phone:	972-548-4623	Ext:		
Fax:				
E-mail:	chill@co.collin.tx.us			2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069
Additional Authorized Signatory for **DocuSign only if applicable (FFATA, Certs, etc)**	Andrea Pease			
Phone:	972-548-4732	Ext:		
Fax:				
E-mail:	apease@co.collin.tx.us			
DocuSign "CC" Person	Christian Jimenez			
Phone:	972-548-5619	Ext:		
Fax:				
E-mail:	cjimenez@co.collin.tx.us			
Emergency Contact	Taylor Burton			Mailing Address (street, city, county, state, & zip):
Cell Phone:	214-973-2023	Ext:		
Fax:				
E-mail:	tburton@co.collin.tx.us			825 N. MCDONALD #130, MCKINNEY, TX 75069

General Instructions for Completing Budget Forms
DSHS Costs Only Budgeted on Detail Category Pages

(Examples and instructions for completing the Budget Category Detail Templates are in a separate Excel file located under Templates for Cost Reimbursement Budgets located at :
http://www.dshs.state.tx.us/grants/forms.shtm

* Enter the legal name of your organization in the space provided for "Legal Name of Respondent" on Form I - Budget Summary; doing so will populate the budget category detail templates with your organizations name.

* Complete each budget category detail template. Instructions for completing each budget category detail template are in a separate document. If a primary budget category detail template does not accommodate all items in your budget, use the respective supplemental budget template at the end of this workbook. The total of each supplemental category detail budget template will automatically populate to the last line of the respective primary budget category template.

* After you have completed each budget category detail form, go to Form I - Budget Summary and input other sources of funding manually (if any) in Columns 3 - 6 for each budget category.

* Refer to the table that is locaated below the budget template table to verify that the amounts distributed ("Distribution Total") in each budget category equals the "Budget Total" for each respective category. Next, verify that the overall total of all distributions ("Distribution Totals") equals the Budget Total.

* Enter the total amount of "Program Income" anticipated for this program in row "K" under the "Total Budget" column (1). The total program income budgeted will be automatically allocated to each funding source based on the percentage of funding of the total budget. Information on program income is available in the Grant Technical Assistance Guide (GTAG) located at the following web site:
https://www.dshs.texas.gov/contracts/gtag.aspx

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	$209,482	$209,482	$0	$0	$0	$0
B. Fringe Benefits	$101,267	$101,267	$0	$0	$0	$0
C. Travel	$4,326	$4,326	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$1,471	$1,471	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$2,110	$2,110	$0	$0	$0	$0
H. Total Direct Costs	$318,656	$318,656	$0	$0	$0	$0
I. Indirect Costs	$35,406	$35,406	$0	$0	$0	$0
J. Total (Sum of H and I)	$354,062	$354,062	$0	$0	$0	$0
K. Program Income - Projected Earnings	$56,500	$56,500				

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**	**$209,482**	**$209,482**	**Fringe Benefits**	**$101,267**	**$101,267**
	Travel	**$4,326**	**$4,326**	**Equipment**	**$0**	**$0**
	Supplies	**$1,471**	**$1,471**	**Contractual**	**$0**	**$0**
	Other	**$2,110**	**$2,110**	**Indirect Costs**	**$35,406**	**$35,406**

TOTAL FOR:	**Distribution Totals**	**$354,062**	**Budget Total**	**$354,062**

*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
Registered Nurse (RN) (Position ID: 201274)	N	Provides immunization services, conducts outreach, and performs audits	0.85	RN License	$8,611.75	12	$87,840
Registered Nurse (RN) (Position ID: 201475)	N	Provides immunization services, conducts outreach, and performs audits	1.00	RN License	$6,789.00	2	$13,578
Community Health Specialist (Position ID: 300456)	N	Manages vaccine inventory, TVFC, and conducts provider quality assurance	1.00	N/A	$4,910.92	12	$58,931
Health Care Analyst (Position ID: 300214)	N	Conducts Perinatal Hep B surveillance and investigations	1.00	N/A	$6,858.08	1	$6,858
Health Care Analyst (Position ID: 200796)	N	Conducts Perinatal Hep B, and vaccine-preventable disease surveillance and investigations	0.10	N/A	$7,474.25	12	$8,969
Epidemiologist (Position ID: 300285)	N	Conducts Perinatal Hep B, and vaccine-preventable disease surveillance and investigations	0.10	N/A	$10,185.17	12	$12,222
Tech I (Position ID: 201467)	N	Provides immunization program support and clerical duties	1.00	N/A	$3,514.00	6	$21,084
							$0
							$0
							$0
							$0
							$0
							$0
					TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS		$0
					SalaryWage Total		$209,482

FRINGE BENEFITS — **Itemize the elements of fringe benefits in the space below:**

a. 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 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 %	48.34%

Revised: 7/6/2009

	Fringe Benefits Total	$101,267

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	
TVFC Annual Training	Annual training for immunization and Texas Vaccines for Children (TVFC) program updates, collaboration with other health departments and regions	Austin, TX	3 days, 1 employee	Mileage	$400
				Airfare	$0
				Meals	$288
				Lodging	$900
				Other Costs	$75
				Total	$1,663
Perinatal Hep B Program Annual Training	Annual training for Perinatal Hep B program updates, collaboration with other health departments and regions	Austin, TX	3 days, 1 employee	Mileage	$400
				Airfare	$0
				Meals	$288
				Lodging	$900
				Other Costs	$75
				Total	$1,663
				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 $3,326

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Mileage reimbursement for local travel costs related to visits completed to healthcare providers, daycares for audits, and unannounced visits. (Note: Internal Revenue Service standard rate utilized; while IRS	714	$0.700	$500		$500
Mileage reimbursement for local travel costs related to day travel for trainings. (Note: Internal Revenue Service standard rate utilized; while IRS rate may vary the costs shall not exceed budgeted amount)	714	$0.700	$500		$500
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					$0

Total for Other / Local Travel $1,000

Other / Local Travel Costs: $1,000 **Conference / Workshop Travel Costs:** $3,326 **Total Travel Costs:** **$4,326**

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

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

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**
Printed Materials: Business Cards ($60/unit x 4)	Business cards for staff to provide contact information during outreach activities	$240
Medical Supplies: Exam Room Table Paper ($70/unit x 5)	Medical supplies for immunization clinic	$350
Medical Supplies: Sharps Containers ($50/unit x 6)	Medical supplies for immunization clinic	$300
Medical Supplies: Alcohol Prep Wipes ($81/unit x 6)	Medical supplies for immunization clinic	$486
Office Supplies: Ballpoint Pens ($10/unit x 2)	Office supplies for program operations	$20
Office Supplies: Notepads Pack ($15/unit x 2)	Office supplies for program operations	$30
Office Supplies: Sticky Notes ($15/unit x 1)	Office supplies for program operations	$15
Office Supplies: Binder Pack ($30/unit x 1)	Office supplies for program operations	$30
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$1,471**

Revised: 7/6/2009

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
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: **Collin County**

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	**Purpose & Justification**	**Total Cost**
Cell Phone Service Plans ($45/month per staff; $45 x 12 months x 3 staff; $45 x 1 month x 1 staff)	Cell phone voice, data, with hotspot service plans to be used by grant staff in order to communicate with local stakeholders and providers	$1,665
Certifications and Staff Training	Departmental trainings for grant staff on HIPAA ($30/unit x 5), Bloodborne Pathogens ($30/unit x 5), Sexual Harassment ($20/unit x 5), CPR certification ($25/unit x 1), Naloxone training ($20/unit x 1)	$445
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$2,110**

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:**	**$35,406**

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	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.	**RATE:** **BASE:**	Rate: 18.24%. Collin County is seeking a 10% de minimis rate on this grant. Type: Indirect Cost Rate Base: Wages & Benefits
____	I elect not to request indirect costs.		

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Revised: 7/6/2009

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
					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
					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
				$0
				$0

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

Total Amount Requested for Equipment: **$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-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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