TEXAS Department of State Health Services

FY26

DIS

Applicant Information

Legal Name of Applicant Agency: Collin County Health Care Services

Mailing Address:

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

Payee Name: Collin County

Payee Mailing Address:

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

State of Texas Comptroller Vendor ID # (11 digit + 3 digit mail code)**:** 17560008736 026

EIN # (12 alphanumeric required for subrecipient contractors)**:** S1ETLA9BNCC5

Fiscal Year-End Date (MM/DD) 02/2026

Type of Entity (Choose one)

Click on appropriate box

City:	☐
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: 8/1/2025
End Date: 2/28/2026

State-wide or Counties Served

State-wide or County(ies) Served: Collin

Amount of Funding Allocated: $388,159.00

CONTACT PERSON INFORMATION

Legal Business Name: Collin County Health Care Services

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 Di Candy Blair
Direct Phone: 972-548-5504 Ext:
E-mail: cblair@co.collin.tx.us
Mailing Address (street, city, county, & zip):
825 N. MCDONALD ST #130, MCKINNEY, TX 75069

B-13 Submitter: Andrea Pease
Direct Phone: 972-548-4731 Ext:
E-mail: apease@co.collin.tx.us
Mailing Address (street, city, county, & zip):
2300 BLOOMDALE RD. MCKINNEY, TX 75069

Program Lead Person: Emeka Ohagi
Direct Phone: 972-548-5559 Ext:
E-mail: eohagi@co.collin.tx.us
Mailing Address (street, city, county, & zip):
825 N. MCDONALD ST #130, MCKINNEY, TX 75069

Contract Lead Person: Bethany MacDonald
Direct Phone: 972-548-5520 Ext:
E-mail: bmacdonald@co.collin.tx.us
Mailing Address (street, city, county, & zip):
825 N. MCDONALD ST #130, MCKINNEY, TX 75069

Contract Authorized Signatory: Chris Hill
Direct Phone: 972-548-4623 Ext:
E-mail: chill@co.collin.tx.us
Mailing Address (street, city, county, & zip):
2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Additional Contract Authorized Sign
Direct Phone: Ext:
E-mail:
Mailing Address (street, city, county, & zip):

FFATA/Assurances Signatory: Andrea Pease
Direct Phone 972-548-4731 Ext:
Mailing Address (street, city, county, & zip):

BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: Collin County Health Care Services

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	$218,592	$218,592			$0	
B. Fringe Benefits	$94,487	$94,487			$0	
C. Travel	$12,738	$12,738			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$2,975	$2,975			$0	
F. Contractual	$0	$0			$0	
G. Other	$24,080	$24,080			$0	
H. Total Direct Costs	$352,872	$352,872	$0	$0	$0	$0
I. Indirect Costs	$35,287	$35,287				
J. Total (Sum of H and I)	$388,159	$388,159	$0	$0	$0	$0
				Match Percentage	0.00%	

Revised: 04/14/2014

PERSONNEL Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

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
Program Coordinator (ID: 300578) - Emeka Ohagi	N	Coordinates DIS grant deliverables and activities; supports DIS grant functions and objectives	1.00	NA	$7,436	6	$44,616
Epidemiologist (Field) (ID: 300582) - Teresa Stelling	N	Conducts field investigations to provide disease intervention for HIV and syphillis, including partner elicitation and notification	1.00	NA	$6,773	6	$40,638
Epidemiologist (Field) (ID: 300581) - Jessica Woods	N	Conducts field investigations to provide disease intervention for HIV and syphillis, including partner elicitation and notification	1.00	NA	$7,192	6	$43,152
Epidemiologist (ID: 300579) - Musa Khan	N	Receives and processes lab reports related to syphilis and other reportable STDs. Initiates field records for DIS related to syphilis and provides education to healthcare providers on CDC treatment guidelines	1.00	NA	$8,184	6	$49,104
Epidemiologist (ID: 300580) - Olivia Jones	N	Receives and processes lab reports related to syphilis and other reportable STDs. Initiates field records for DIS related to syphilis and provides education to healthcare providers on CDC treatment guidelines	1.00	NA	$6,847	6	$41,082
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS			$0
					SalaryWage Total		$218,592

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

Total Number of FTEs:	**5.00**		**Fringe Benefit Rate %**	43.23%
			Fringe Benefits Total	$94,487

TRAVEL Budget Category Detail Form

Legal Name of Respondent: Collin County Health Care Services

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days & Employees	Travel Costs	
STD Central Office Trainings, In State STD Surveillance, or DIS Training (1)	Staff to attend STD Central Office training to find new innovated information and skills to assist in the investigation of HIV/STD and public health follow up activities. Mileage expenses included to offset staff round-trip reimbursement to airport using personal vehicle and mileage reimbursement expenses in the scenario if staff opts for ground travel to training destination using personal vehicle	TBD	4 days/1 staff (Emeka Ohagi, Olivia Jones, Musa Khan, Jessica Woods, or Teresa Stelling)	Mileage	$250
				Airfare	$750
				Meals	$256
				Lodging	$1,200
				Other Costs	$375
				Total	$2,831
Texas HIV STD Program Managers Meeting	DIS Program Manager to travel for DSHS's Program Managers meeting. Other costs included to offset travel-related rental vehicle expenses to navigate local training region when flying into nearest destination airport for training, and related airport parking fees, and any related Cab/Taxi/Tollway fees for staff.	TBD	4 days/1 staff (Emeka Ohagi)	Mileage	$600
				Airfare	$750
				Meals	$300
				Lodging	$1,200
				Other Costs	$500
				Total	$3,350
STD Central Office Trainings, In State STD Surveillance, or DIS Training (2)	Staff to attend STD Central Office training to find new innovated information and skills to assist in the investigation of HIV/STD and public health follow up activities. Mileage expenses included to offset staff round-trip reimbursement to airport using personal vehicle and mileage reimbursement expenses in the scenario if staff opts for ground travel to training destination using personal vehicle	TBD	4 days/1 staff (Emeka Ohagi, Olivia Jones, Musa Khan, Jessica Woods, or Teresa Stelling)	Mileage	$250
				Airfare	$750
				Meals	$256
				Lodging	$1,200
				Other Costs	$375
				Total	$2,831
				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 $9,012

Revised: 3/25/2014

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Reimbursable mileage for staff to conduct local travel for DIS grant related activities. (Staff: Emeka Ohagi, Teresa Stelling, Jessica Woods, Musa Khan, Olivia	4523	$0.700	$3,166		$3,166
Local training travel including day travel throughout DFW metroplex. (Staff: Emeka Ohagi, Teresa Stelling, Jessica Woods, Musa Khan, Olivia Jones)	800	$0.700	$560		$560
			$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 $3,726

Other / Local Travel Costs: $3,726 **Conference / Workshop Travel Costs:** $9,012 **Total Travel Costs:** **$12,738**

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

Revised: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent: **Collin County Health Care Services**

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
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 Health Care Services**

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**
Office Supplies	Items to include: Writing Pads ($10/unit x 5 = $50), Pens ($15/unit x 3 = $45), Planners ($35/unit x 5 = $175), Label Tape ($40/unit x 2 = $80), Packing Tape ($25/unit x 5 = $125), Bubble Wrap ($100/unit x 5 = $500), 2-Pocket Folders ($25/pack x 5 = $125), Calendars ($25/each x 5 = $125), to include surge staff that would assist DIS program in case of outbreak response to produce reports, documentation, and support grant functions and operations.	$1,225
Grant Program Supplies	Insulated Shipping systems ($315/unit x 5 = $1,575), absorbent strips ($100/unit x 1), cold packs ($15/unit x 5 = $75), for DIS program public health follow-up activites	$1,750
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Revised: 3/25/2014

Total Amount Requested for Supplies:	**$2,975**

CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: **Collin County Health Care Services**

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 Health Care Services**

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
Postage	Postage for outreach materials, mailings, and communications with stakeholders.	$1,250
5x Cell Phone Service Plans ($50/month x 5 staff x 6 months = $1,500)	Voice and Data Plans for cell phones for communication with clients in the field while conducting public health follow-up activities.	$1,500
5x Cell Phone Internet Hotspot ($5/month x 5 staff x6 months)	Mobile hotspot on cell phones for connecting to the internet in the field and for remote work.	$150
Specimen Collection Laboratory Fees - Syphilis (estimated $45/unit x 86 lab submissions = $3,870.00)	Specimen collection fees for DIS program to cover lab fees for full panel STD infections to include syphilis. Lab to be used is subject to Collin County Purchasing Department quotes and agreements. Purchasing may elect to change vendors in the future.	$3,870
Specimen Collection Laboratory Fees - Chlamydia (estimated $30/unit x 86 lab submissions = $2,580.00)	Specimen collection fees for DIS program to cover lab fees for full panel STD infections to include chlamydia. Lab to be used is subject to Collin County Purchasing Department quotes and agreements. Purchasing may elect to change vendors in the future.	$2,580
Specimen Collection Laboratory Fees - Gonorrhea (estimated $30/unit x 86 lab submissions = $2,580.00)	Specimen collection fees for DIS program to cover lab fees for full panel STD infections to include gonorrhea. Lab to be used is subject to Collin County Purchasing Department quotes and agreements. Purchasing may elect to change vendors in the future.	$2,580
Specimen Collection Laboratory Fees - HIV (estimated $100/unit x 113 lab submissions = $11,300.00)	Specimen collection fees for DIS program to cover lab fees for full panel STD infections to include HIV. Lab to be used is subject to Collin County Purchasing Department quotes and agreements. Purchasing may elect to change vendors in the future.	$11,300

Printing and Communication Materials	Printing for additional grant related activities, events and public education or other outreach brochures ($0.20/unit x 300 = $60), flyers ($0.20/unit x 300 = $60), postcards ($0.06/unit x 250 = $15), posters ($0.20/unit x 300= $60) and other materials to educate the public; printing of employee business cards ($80/box of business cards x 5 staff = $400), inner envelopes to deliver sensitive information ($40/unit x 3 = $120), outer envelopes ($45/unit x 3 = $135).	$850
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$24,080**

Indirect Costs

Legal Name of Respondent:	**Collin County Health Care Services**
Total amount of indirect costs allocable to the project:	**Amount:** **$35,287**

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)**	**RATE:**	Rate: 18.24%
	BASE:	In the process of negotiating federal rate.Collin County is seeking a 10% de minimis rate on this grant. Type: Indirect Cost Rate Base: Wages & Benefits

***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.*

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.
	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 Health Care Services

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
			0.00				
					SalaryWage Total		$0

PERSONNEL Budget Category Detail Form (Match)

Legal Name of Respondent: Collin County Health Care Services

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
					SalaryWage Total		$0

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

	Fringe Benefit Rate %	
	Fringe Benefits Total	$0

TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: Collin County Health Care Services

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: 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
			$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: 3/25/2014

TRAVEL Budget Category Detail Form (Match)

Legal Name of Respondent: Collin County Health Care Services

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: 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
			$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: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Supplemental)

Legal Name of Respondent: Collin County Health Care Services

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

EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Match)

Legal Name of Respondent: Collin County Health Care Services

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

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

Revised: 3/25/2014

SUPPLIES Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Collin County Health Care Services**

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 Health Care Services**

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 Health Care Services

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 Health Care Services

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 Health Care Services

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: 3/25/2014

OTHER COSTS Budget Category Detail Form (Match)

Legal Name of Respondent: **Collin County Health Care Services**

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: 3/25/2014