



**FY26- TB STATE
TB/PC STATE**

Applicant Information

**Legal Name of Applicant Agency:
Mailing Address:**

Collin County

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):

17560008736000

DUNS # (9 digits required for subrecipient contractors):

S1ETLA9BNCC5

Fiscal Year-End Date (MM/DD)

08/31

Type of Entity (Choose one)

City: ☐ Click on appropriate box
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: 9/1/2025
End Date: 8/31/2026

State-wide or Counties Served

State-wide or County(ies) Served:

Collin

Amount of Funding Allocated:

\$299,747.00

CONTACT PERSON INFORMATION

Legal Business Name:

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 Director:
Direct Phone: Ext:
E-mail:

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

B-13 Submitter:
Direct Phone: Ext:
E-mail:

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

Program Lead Person:
Direct Phone: Ext:
E-mail:

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

Contract Lead Person:
Direct Phone: Ext:
E-mail:

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

Contract Authorized Signatory:
Direct Phone: Ext:
E-mail:

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

Additional Contract Authorized Signatory:
Direct Phone: Ext:
E-mail:

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

FFATA/Assurances Signatory:
Direct Phone: Ext:

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

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	\$216,400	\$174,087			\$42,313	
B. Fringe Benefits	\$105,692	\$88,056			\$17,636	
C. Travel	\$1,000	\$1,000			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$5,309	\$5,309			\$0	
F. Contractual	\$0	\$0			\$0	
G. Other	\$1,320	\$1,320			\$0	
H. Total Direct Costs	\$329,721	\$269,772	\$0	\$0	\$59,949	\$0
I. Indirect Costs	\$29,975	\$29,975				
J. Total (Sum of H and I)	\$359,696	\$299,747	\$0	\$0	\$59,949	\$0
				Match Percentage	20.00%	

PERSONNEL Budget Category Detail Form

Legal Name of Respondent:

Collin County[illegible]

FRINGE BENEFITS

Itemize the elements of fringe benefits in the space below:

a. Fringe Benefits: FICA/Medicare (salary x 0.0765), Insurance Premiums (Salary x 1.5) + (50000/1000)*0.127)*12)+(1700*12), Long Term Disability (salary x 0.0024), Short Term Disability (\$2.10*12), Long Term Care (30.08*12), 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 0.127 which includes ADD.

Total Number of FTEs:	3.00	Fringe Benefit Rate %	50.58%
		Fringe Benefits Total	\$88,050

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

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Mileage reimbursement for staff to conduct home-visits to TB patients, visits to providers office for TB education/presentations, and site visits for contact	714	\$0.700	\$500		\$500
Mileage reimbursement for staff to attend trainings, educational events, and related local TB program travel activities (Note: Internal Revenue Service	714	\$0.700	\$500		\$500
			\$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

\$1,000

Other / Local Travel Costs: \$1,000

Conference / Workshop Travel Costs: \$0

Total Travel Costs: \$1,000

Indicate Policy Used:

Respondent's Travel Policy Yes

State of Texas Travel Policy

Revised: 3/25/2014

Legal Name of Respondent:

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
Printed Materials: Business Cards (\$60/unit x 3)	Business cards for staff to provide contact information during outreach activities	\$180
Medical Supplies: Reusable Blood Pressure Cuff (est. \$35/unit x 35)	Reusable blood pressure cuffs that are critical for TB patients at-home use which provide accurate and reliable blood pressure readings	\$1,225
Medical Supplies: Pulse Oximeters (est. \$43/unit x 35)	Oximeter devices that are critical for TB patient at-home use for success in the program	\$1,505
Medical Supplies: Blood Pressure Monitors (est. \$80/unit x 29)	Blood pressure monitoring devices that are critical for TB patient at-home use for success in the program	\$2,320
Office Supplies: Ballpoint Pens (\$10/unit x 1)	Office supplies for program operations	\$10
Office Supplies: Notepads Pack (\$12/unit x 1)	Office supplies for program operations	\$12
Office Supplies: Sticky Notes (\$15/unit x 1)	Office supplies for program operations	\$15
Office Supplies: Binder Pack (\$42/unit x 1)	Office supplies for program operations	\$42
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Supplies:

\$5,309

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	Trainings for grant staff on HIPAA (\$30/unit x 3), Blood Borne Pathogens (\$30/unit x 3), Sexual Harrassment (\$20/unit x 3), CPR Certification (\$30/unit x 3), Saf-T Pak Certification (\$110/unit x 3), and First-Aid Opioid Overdose trainings (\$20/unit x 3)	\$720
Uniforms for Clinical Staff (\$200/per staff x 3 staff)	Uniforms for grant clinical staff safety and identification while working in clinic, or offsite meetings, offsite trainings	\$600
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$1,320

Indirect Costs

Legal Name of Respondent:

Collin County

Total amount of indirect costs allocable to the project:

Amount: \$29,975

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: In the process of negotiating federal rate.

BASE:

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.

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

☐ 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

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

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
Ly Vang (Position ID: 201275) - Registered Nurse	N	Provides nurse case management of TB cases and contacts	0.48	License	\$7,411	12	\$42,313
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
						SalaryWage Total	\$42,313

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 % 41.68%
	Fringe Benefits Total \$17,636

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: 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**

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

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

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.

[illegible]

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.

[illegible]

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

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

Total Amount Requested for Other:

\$0