TEXAS Department of State Health Services

FY26- TB FED

TB/PC FED

Applicant Information

Legal Name of Applicant Agency: Collin County

Mailing Address:

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

Payee Name: Collin County

Payee Mailing Address:

Street / PO Box: 825 N. McDonald #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 (Unique ID)

Fiscal Year-End Date (MM/DD) 08/31

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

State-wide or Counties Served

State-wide or County(ies) Served: Collin

Amount of Funding Allocated: $84,572.00

CONTACT PERSON INFORMATION

Legal Business Name: Collin County

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

B-13 Submitter: Andrea Pease
Direct Phone: 972-548-4732 Ext:
E-mail: apease@co.collin.tx.us
Mailing Address (street, city, county, & zip):
2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

Program Lead Person: Candice Christian
Direct Phone: 972-548-5509 Ext:
E-mail: cchristian@co.collin.tx.us
Mailing Address (street, city, county, & zip):
825 N. MCDONALD #130, MCKINNEY, TX 75069

Contract Lead Person: Taylor Burton
Direct Phone: 972-548-4464 Ext:
E-mail: tburton@co.collin.tx.us
Mailing Address (street, city, county, & zip):
825 N. MCDONALD #130, MCKINNEY, TX 75069

Contract Authorized Signatory: Chris Hill
Direct Phone: 972-548-4632 Ext:
E-mail: chill@co.collin.tx.us
Mailing Address (street, city, county, & zip):
2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069

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

FFATA/Assurances Signatory: Andrea Pease
Direct Phone 972-548-4732 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	$56,454	$45,562			$10,892	
B. Fringe Benefits	$32,350	$26,328			$6,022	
C. Travel	$250	$250			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$3,845	$3,845			$0	
F. Contractual	$0	$0			$0	
G. Other	$130	$130			$0	
H. Total Direct Costs	$93,029	$76,115	$0	$0	$16,914	$0
I. Indirect Costs	$8,457	$8,457				
J. Total (Sum of H and I)	$101,486	$84,572	$0	$0	$16,914	$0
				Match Percentage	20.00%	

Revised: 04/14/2014

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)	N	Serves as TB case registrar, performing TB data collection and reporting duties	0.80	N/A	$4,746	12	$45,562
							$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		$45,562

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:	**0.80**		**Fringe Benefit Rate %**	57.78%
			Fringe Benefits Total	$26,328

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	
				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)
Local mileage reimbursement for the following staff (Cynthia Leung (Medical Assistant) ID: 300176; to conduct contact investigations, screening, DOT, and	357	$0.700	$250		$250
			$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 $250

Other / Local Travel Costs: $250 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** **$250**

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

Revised: 3/25/2014

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**
Medical Supplies: Blood Pressure Monitors (est. $80/unit x 31)	Blood pressure monitoring devices that are critical for TB patient at-home use for success in the program	$2,480
Medical Supplies: Pulse Oximeters (est. $43/unit x 29)	Oximeter devices that are critical for TB patient at-home use for success in the program	$1,247
Office Supplies: Ballpoint Pens ($10/unit x 2)	Office supplies for program operations	$20
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: Planner ($20/unit x 1)	Office supplies for program operations	$20
Office Supplies: Paper Clips ($11/unit x 1)	Office supplies for program operations	$11
Office Supplies: Binder Clips ($10/unit x 4)	Office supplies for program operations	$40
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$3,845**

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
Certifications and Staff Training	Departmental trainings for grant staff on HIPAA ($30/unit x 1), Bloodborne Pathogens ($30/unit x 1), Sexual Harassment ($20/unit x 1), CPR certification ($30/unit x 1), First-Aid for Opioid Overdoses ($20/unit x 1)	$130
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$130**

Revised: 3/25/2014

Indirect Costs

Legal Name of Respondent:	**Collin County**
Total amount of indirect costs allocable to the project:	**Amount:** **$8,457**

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.*

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:** **TYPE:** **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.

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
			0.00				
					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
Brittani Rogers - TB Outreach (Position ID: 201476)	N	Provides DOT to TB Patients	0.21	N/A	$4,322	12	$10,892
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$10,892

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 %	55.29%
Fringe Benefits Total	$6,022

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

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

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

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

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**

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

Revised: 3/25/2014

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**

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

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

Revised: 3/25/2014

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

Revised: 3/25/2014