



**FY26**

Contract Type: IDPS/SUR

**Applicant Information**

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

COLLIN COUNTY

Street / PO Box: 825 N MCDONALD ST #130  
City: MCKINNEY, TX  
Zip: 75069

**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):

17560008736026

**EIN #** (12 alphanumeric 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:**

\$171,223.00

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 Director: 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: 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

Program Lead Person: Dr. Jawaid Asghar
Direct Phone: 972-548-5534 Ext:
E-mail: jasghar@co.collin.tx.us

Mailing Address (street, city, county, & zip):
825 N. MCDONALD ST #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 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 Signatory:
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

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	\$112,644	\$112,644			\$0	
B. Fringe Benefits	\$41,340	\$41,340			\$0	
C. Travel	\$117	\$117			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$0	\$0			\$0	
F. Contractual	\$0	\$0			\$0	
G. Other	\$0	\$0			\$0	
H. Total Direct Costs	\$154,101	\$154,101	\$0	\$0	\$0	\$0
I. Indirect Costs	\$17,122	\$17,122				
J. Total (Sum of H and I)	\$171,223	\$171,223	\$0	\$0	\$0	\$0
				<b>Match Percentage</b>	<b>0.00%</b>	



## 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													
				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Mileage</td><td></td></tr> <tr><td>Airfare</td><td></td></tr> <tr><td>Meals</td><td></td></tr> <tr><td>Lodging</td><td></td></tr> <tr><td>Other Costs</td><td></td></tr> <tr><td style="text-align: right;"><b>Total</b></td><td style="text-align: right;">\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		<b>Total</b>	\$0
Mileage																
Airfare																
Meals																
Lodging																
Other Costs																
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Airfare	\$0															
Meals	\$0															
Lodging	\$0															
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Mileage	\$0															
Airfare	\$0															
Meals	\$0															
Lodging	\$0															
Other Costs	\$0															
<b>Total</b>	\$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)
Out of office meetings, seminars, exercises, training, including day travel within DFW metroplex. Will be utilized by all IDPS-SUR funded staff (Aisha Souri).	167	\$0.700	\$117		\$117
			\$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**

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

**Total Travel Costs:**

Indicate Policy Used:

Respondent's Travel Policy

State of Texas Travel Policy





## 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**



## Indirect Costs

Legal Name of Respondent:

COLLIN COUNTY

Total amount of indirect costs allocable to the project:

Amount: \$17,122

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:**

**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.

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	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
			0.00			<b>SalaryWage Total</b>	<b>\$0</b>

**PERSONNEL Budget Category Detail Form (Match)**

Legal Name of Respondent:

COLLIN COUNTY

<b>PERSONNEL</b>							
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
<b>SalaryWage Total</b>							<b>\$0</b>

<b>FRINGE BENEFITS</b>	
Itemize the elements of fringe benefits in the space below:	
	<b>Fringe Benefit Rate %</b>
	<b>Fringe Benefits Total</b>
	<b>\$0</b>

## 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	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$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	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$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









## 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
						\$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
						\$0

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



