FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: Fort Bend County Clinical Health Services

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	$96,800	$96,800	$0	$0	$0	$0
B. Fringe Benefits	$45,622	$45,622	$0	$0	$0	$0
C. Travel	$14,230	$14,230	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$13,800	$13,800	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$18,600	$18,600	$0	$0	$0	$0
H. Total Direct Costs	$189,052	$189,052	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$189,052	$189,052	$0	$0	$0	$0
K. Program Income - Projected Earnings	$0	$0				

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**	**$96,800**	**$96,800**	**Fringe Benefits**	**$45,622**	**$45,622**
	Travel	**$14,230**	**$14,230**	**Equipment**	**$0**	**$0**
	Supplies	**$13,800**	**$13,800**	**Contractual**	**$0**	**$0**
	Other	**$18,600**	**$18,600**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$189,052**	**Budget Total**	**$189,052**

*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.