FORM I: BUDGET SUMMARY (REQUIRED)

FY 2020 TB/PC FEDERAL
Legal Name of Respondent: FORT BEND 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	$52,440	$52,440			$0	
B. Fringe Benefits	$22,560	$22,560			$0	
C. Travel	$8,640	$8,640			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$0	$0			$0	
F. Contractual	$35,384	$15,546			$19,837	
G. Other	$0	$0			$0	
H. Total Direct Costs	$119,024	$99,186	$0	$0	$19,837	$0
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$119,024	$99,186	$0	$0	$19,837	$0
K. Program Income - Projected Earnings	$0	$0	$0	$0	$0	$0

NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts in whole dollars for (3), (4), & (6), *if applicable*. 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**	**$52,440**	**$52,440**	**Fringe Benefits**	**$22,560**	**$22,560**
	Travel	**$8,640**	**$8,640**	**Equipment**	**$0**	**$0**
	Supplies	**$0**	**$0**	**Contractual**	**$35,383**	**$35,384**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	Distribution Totals	$119,023	Budget Total	$119,024

*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.

FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent: FORT BEND COUNTY

PERSONNEL Name + Functional Title E = Existing or P = Proposed	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Delores OllieLPN, DOT/CI - E	N	Provide DOT/DOPT servvices to TB patients, contacts, suspects. Initiate and complete contact investigations releated to cases and suspects in the county and those referred by outside agencies. Instruct, demonstrate, view VDOT for TB patients, suspects, 3HP and LTBI patients assigned.	1	LPN	$4,370.00	12	$52,440
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$52,440

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

FICA 7.65%, Pension 12.12%, Workman's Comp 1%, property & Casualty 2.8%, Health Insurance per FTE $10,200.00

	Fringe Benefit Rate %	43.02%
	Fringe Benefits Total	$22,560

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: FORT BEND COUNTY

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
Texas TB conference	TB program manager and 1 additional staff would benefit from the presentation and workshops offered. New case manager training to occur at this conference.	Austin/TX	4/2	Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$350
				Total	$350
				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
				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 $350

Revised: 1/27/2012

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
DOT/DOPT/VDOT training suspects,cases, TBII on 3HP therapy. Contact investigation of suspects and cases in Fort Bend County. Travel to local meetings	14293	$0.580	$8,290		$8,290
			$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 $8,290

Other / Local Travel Costs: $8,290 **Conference / Workshop Travel Costs:** $350 **Total Travel Costs:** **$8,640**

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

Revised: 1/27/2012

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent: FORT BEND 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
				$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: 1/27/2012

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent: FORT BEND 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.) See attached example for definition of supplies and detailed instructions to complete this form.

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 1/27/2012

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: FORT BEND 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., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly rate, unit rate, lump sum amount)	TOTAL
Oak Bend Medical Center	Chest x-rays	Diagnosis/Management of TB patients	Unit	100	$45.00	$4,500
West Houston Radiology	Reading of Chest x-rays	Diagnosis/Management of TB patients	Unit	111	$15.00	$1,665
Oak Bend Medical Center	CT Chest Scan	Diagnosis/Management of TB patients	Unit	2	$406.00	$812
West Houston Radiology	Reading of CT Chest Scan	Diagnosis/Management of TB patients	Unit	2	$100.00	$200
Fort Bend Imaging	Chest x-rays/Reading of Chest x-rays	Diagnosis/Management of TB patients	Unit	66	$30.00	$1,980
Various	DOT providers	Assist with delivery of TB medications to patients via DOT	Unit	182	$35.00	$6,390
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for CONTRACTUAL: $15,547

Revised: 1/27/2012