



FY2021

**Applicant Information**

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

Fort Bend County

Street / PO Box: 301 Jackson Street  
City: Richmond  
Zip: 77469-3108

**Payee Name:**

Fort Bend County Auditor

**Payee Mailing Address:**

Street / PO Box: 301 Jackson Street, Suite 701  
City: Richmond  
Zip: 77469-3108

**State of Texas Comptroller Vendor ID #** (9 digit + 3 digit mail code):  
**DUNS #** (9 digits required for subrecipient contractors):

746001969  
81497075

**Type of Entity (Choose one)**

City:  Click on appropriate box  
County:   
Other Political Subdivision:

**Project Period**

Start Date: 1/1/2021  
End Date: 12/31/2021

**Counties Served**

County(ies) Served:  
  
Fort Bend County

**Amount of Funding Allocated:**

\$99,186.00

**CONTACT PERSON INFORMATION**

Legal Business Name:

*This form provides information about the appropriate contacts in the contractor's organization in addition to those on the FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Management Unit.*

Health Director/CEO   
Phone:  Ext:   
Fax:   
E-mail:

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

B-13/FSR Rep:   
Phone:  Ext:   
Fax:   
E-mail:

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

PHEP (HAZARDS) Program Leader:   
Phone:  Ext:   
Fax:   
E-mail:

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

SNS (CRI) Coordinator:   
Phone:  Ext:   
Fax:   
E-mail:

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

Authorized Signatory for **DocuSign**   
Phone:  Ext:   
Fax:   
E-mail:

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

**Additional** Authorized Signatory for   
**DocuSign only if applicable**  
**(FFATA, Certs, etc)**  
Phone:  Ext:   
Fax:   
E-mail:

**DocuSign "CC" Person**   
Phone:  Ext:   
Fax:   
E-mail:

Emergency Contact   
Cell Phone:  Ext:   
Fax:   
E-mail:

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

## BUDGET SUMMARY (REQUIRED)

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	\$53,016	\$53,016			\$0	
B. Fringe Benefits	\$26,397	\$26,397			\$0	
C. Travel	\$2,546	\$2,546			\$0	
D. Equipment	\$1,500	\$1,500			\$0	
E. Supplies	\$1,010	\$1,000			\$10	
F. Contractual	\$34,554	\$14,727			\$19,827	
G. Other	\$0	\$0			\$0	
H. Total Direct Costs	\$119,023	\$99,186	\$0	\$0	\$19,837	\$0
I. Indirect Costs	\$0	\$0				
J. Total (Sum of H and I)	\$119,023	\$99,186	\$0	\$0	\$19,837	\$0
				Match Percentage	<b>20.00%</b>	

If the Contractor is using Indirect Costs as Match, then enter the amount in Line 16, Column H.



## 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:	Travel Costs	
			Days & Employees		
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	\$0
				Airfare	\$0
				Meals	\$0
				Lodging	\$0
				Other Costs	\$0
				<b>Total</b>	\$0
				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)
DOT/DOPT/VDOT training of suspects, cases, LTBI. Contact investigations of suspects and cses in Fort Bend County.	4390	\$0.580	\$2,546		\$2,546
			\$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** \$2,546

Other / Local Travel Costs: \$2,546

Conference / Workshop Travel Costs: \$0

**Total Travel Costs:** \$2,546

Indicate Policy Used:

Respondent's Travel Policy

State of Texas Travel Policy

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 Cost
Vital signs monitor	Provide proper vital signs monitoring for TB patients.	1	\$1,500	\$1,500
				\$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: \$1,500

## 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.)

Description of Item <small>Provide estimated quantity and cost</small>	Purpose & Justification	Total Cost
Clinic and office supplies for TB patients	Day to day operations	\$1,000
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Supplies:

**\$1,000**

## 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., 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
Oakbend Medical Center	Chest x-rays	Diagnosis/Management of TB patients.	Unit	120	\$45.00	\$5,400
Singleton Radiology	Reading of Chest x-rays	Diagnosis/Management of TB patients.	Unit	120	\$15.00	\$1,800
Oakbend Medical Center	CT Chest Scan	Diagnosis/Management of TB patients.	Unit	2	\$406.00	\$812
Singleton 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 xrays	Diagnosis/Management of TB patients	Unit	167	\$30.00	\$5,010
Staffing Solutions	DOT providers	Provide directly observed therapy for TB patients	Unit	43	\$35.00	\$1,505
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL: **\$14,727**



# Indirect Costs

**Legal Name of Respondent:**

**Fort Bend County**

**Total amount of indirect costs allocable to the project:**

**Amount:**

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 (Form I - 7 Indirect)

**RATE:**  
**BASE:**

*Applies only to governmental entities.* The respondent's current central service cost rate or indirect cost rate. Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.

**Note:** Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

**RATE:**  
**TYPE:**  
**BASE:**

A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date.

**GO TO PAGE 2 (below)**

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**

## **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 (Match)

Legal Name of Respondent:

**Fort Bend 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
							\$0
							\$0
						<b>Salary/Wage Total</b>	<b>\$0</b>

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

## TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: **Fort Bend County**

<b>Conference / Workshop Travel Costs</b>					
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**

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

**Total Travel Costs:**

## TRAVEL Budget Category Detail Form (Match)

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	
				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**

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

**Total Travel Costs:**









## CONTRACTUAL Budget Category Detail Form (Supplemental)

**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 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:** **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 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
Oakbend Medical Center	Chest x rays	Diagnosis/Management of TB patients		120	\$45.00	\$5,400
Singleton Radiology	Reading of chest xrays	Diagnosis/Management of TB patients		120	\$15.00	\$1,800
Oakbend Medical Center	CT Chest Scan	Diagnosis/Management of TB patients		2	\$406.00	\$812
Singelton Radiology	Reading of CT scan	Diagnosis/Management of TB patients		2	\$100.00	\$200
Fort Bend Imaging	Chest xrays/reading of Chest xrays	Diagnosis/Management of TB patients		120	\$30.00	\$3,600
Staffing Solutions	DOT providers	Provide directly observed therapy for TB patients		229	\$35.00	\$8,015
						\$0
						\$0
						\$0
						\$0

Total Amount Requested for CONTRACTUAL: **\$19,827**



