# 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 (Match) (5) | Other Funds (6) |
|---|---|---|---|---|---|---|
| A. Personnel | $92,104 | $65,225 | | | $26,879 | |
| B. Fringe Benefits | $35,625 | $35,625 | | | $0 | |
| C. Travel | $452 | $452 | | | $0 | |
| D. Equipment | $0 | $0 | | | $0 | |
| E. Supplies | $20 | $20 | | | $0 | |
| F. Contractual | $33,075 | $33,075 | | | $0 | |
| G. Other | $0 | $0 | | | $0 | |
| H. Total Direct Costs | $161,276 | $134,397 | $0 | $0 | $26,879 | $0 |
| I. Indirect Costs | $0 | $0 | | | $0 | |
| J. Total (Sum of H and I) | $161,276 | $134,397 | $0 | $0 | $26,879 | $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** | **$92,104** | **$92,104** | **Fringe Benefits** | **$35,625** | **$35,625** |
| | **Travel** | **$452** | **$452** | **Equipment** | **$0** | **$0** |
| | **Supplies** | **$20** | **$20** | **Contractual** | **$33,075** | **$33,075** |
| | **Other** | **$0** | **$0** | **Indirect Costs** | **$0** | **$0** |

| | | | | |
|---|---|---|---|---|
| **TOTAL FOR:** | **Distribution Totals** | **$161,276** | **Budget Total** | **$161,276** |

*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 Clinical Health Services

| PERSONNEL<br>Name + Functional Title<br>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 |
|---|---|---|---|---|---|---|---|
| MyShonique Jackson | N | DOT/VDOT,Contact investigation. Collects blood for IGRA's, HIV, Hepatitis Panel, TB panel. Performs outside referral investigations, organizes archive TB records, and collects and distributes disaster and educational packets. | 1 | LVN | $3,607.41 | 12 | $43,289 |
| Jeanette Munoz, DOT/ Contact Investigator | N | DOT/VDOT,Contact investigation. Collects blood for IGRA's, HIV, Hepatitis Panel, TB panel. Performs outside referral investigations, organizes archive TB records, and collects and distributes disaster and educational packets. | 0.5 | LVN | $1,908.00 | 12 | $21,936 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | | | | $0 |
| | | | | TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS | | | $0 |
| | | | | | SalaryWage Total | | $65,225 |

**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 % | 54.62% |
| Fringe Benefits Total | $35,625 |

# FORM I-2: TRAVEL Budget Category Detail Form

**Legal Name of Respondent:** Fort Bend County Clinical Health Services

## Conference / Workshop Travel Costs

| Description of Conference/Workshop | Justification | Location City/State | Number of: Days/Employees | Travel Costs | |
|---|---|---|---|---|---|
| | | | | Mileage | $0 |
| | | | | Airfare | $0 |
| | | | | Meals | $0 |
| | | | | Lodging | |
| | | | | 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 |
| | | | | 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) |
|---|---|---|---|---|---|
| DOT/Contact investigation | 779 | $0.580 | | | $452 |
| | | | $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** $452

**Other / Local Travel Costs:** $452 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** $452

**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 Clinical Health Services

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 |
| | | | | $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 Clinical Health Services**

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** |
|---|---|---|
| General Supplies | Paper, pens, pencils etc. | 20.00 |
| | | |
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| | | |

**$20**

# FORM I-5: CONTRACTUAL Budget Category Detail Form

**Legal Name of Respondent:** Fort Bend County Clinical Health Services

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 |
|---|---|---|---|---|---|---|
| Various | DOT providers | Personal service contracts. Personal contract has trained individuals for assistance with administration of TB meds. | Personal- per dose administered. | 945 | $35.00 | $33,075 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | | | $0 |
| | | | | TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS | | $0 |

**Total Amount Requested for CONTRACTUAL:** **$33,075**