



FY2022

Applicant Information

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

Fort Bend County

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

Payee Name:

Fort Bend County Auditor

Payee Mailing Address:

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

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: 6/30/2024

Counties Served

County(ies) Served:

Fort Bend County

Amount of Funding Allocated:

\$98,840.00

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):

IMM/LOCALS Program Leader:
Phone: Ext:
Fax:
E-mail:

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

IMM/LOCALS 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):

General Instructions for Completing Budget Forms DSHS Costs Only Budgeted on Detail Category Pages

(Examples and instructions for completing the Budget Category Detail Templates are in a separate Excel file located under Templates for Cost Reimbursement Budgets located at :

<http://www.dshs.state.tx.us/grants/forms.shtm>

- * Enter the legal name of your organization in the space provided for "Legal Name of Respondent" on Form I - Budget Summary; doing so will populate the budget category detail templates with your organizations name.
- * Complete each budget category detail template. Instructions for completing each budget category detail template are in a separate document. If a primary budget category detail template does not accommodate all items in your budget, use the respective supplemental budget template at the end of this workbook. The total of each supplemental category detail budget template will automatically populate to the last line of the respective primary budget category template.
- * After you have completed each budget category detail form, go to Form I - Budget Summary and input other sources of funding manually (if any) in Columns 3 - 6 for each budget category.
- * Refer to the table that is located below the budget template table to verify that the amounts distributed ("Distribution Total") in each budget category equals the "Budget Total" for each respective category. Next, verify that the overall total of all distributions ("Distribution Totals") equals the Budget Total.
- * Enter the total amount of "Program Income" anticipated for this program in row "K" under the "Total Budget" column (1). The total program income budgeted will be automatically allocated to each funding source based on the percentage of funding of the total budget. Information on program income is available in the Grant Technical Assistance Guide (GTAG) located at the following web site:
<https://www.dshs.texas.gov/contracts/gtag.aspx>

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent:

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	\$0	\$0	\$0	\$0	\$0	\$0
B. Fringe Benefits	\$0	\$0	\$0	\$0	\$0	\$0
C. Travel	\$168	\$168	\$0	\$0	\$0	\$0
D. Equipment	\$21,278	\$21,278	\$0	\$0	\$0	\$0
E. Supplies	\$28,014	\$28,014	\$0	\$0	\$0	\$0
F. Contractual	\$46,720	\$46,720	\$0	\$0	\$0	\$0
G. Other	\$2,660	\$2,660	\$0	\$0	\$0	\$0
H. Total Direct Costs	\$98,840	\$98,840	\$0	\$0	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$98,840	\$98,840	\$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 Category	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	Personnel	\$0	\$0	Fringe Benefits	\$0	\$0
	Travel	\$168	\$168	Equipment	\$21,278	\$21,278
	Supplies	\$28,014	\$28,014	Contractual	\$46,720	\$46,720
	Other	\$2,660	\$2,660	Indirect Costs	\$0	\$0

TOTAL FOR:	Distribution Totals	\$98,840	Budget Total	\$98,840
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*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:

0

PERSONNEL	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	
Functional Title + Code E = Existing or P = Proposed								
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
							\$0	
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS								\$0
						SalaryWage Total	\$0	

FRINGE BENEFITS	Itemize the elements of fringe benefits in the space below:
Fringe Benefit Rate %	
0.00%	
Fringe Benefits Total	
\$0	

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

0

Conference / Workshop Travel Costs																	
Description of Conference/Workshop	Justification	Location City/State	Number of:		Travel Costs												
			Days	Employees													
					<table border="1"> <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>Total</td><td>\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		Total	\$0
Mileage																	
Airfare																	
Meals																	
Lodging																	
Other Costs																	
Total	\$0																
					<table border="1"> <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>Total</td><td>\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		Total	\$0
Mileage																	
Airfare																	
Meals																	
Lodging																	
Other Costs																	
Total	\$0																
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Mileage																	
Airfare																	
Meals																	
Lodging																	
Other Costs																	
Total	\$0																
					<table border="1"> <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>Total</td><td>\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		Total	\$0
Mileage																	
Airfare																	
Meals																	
Lodging																	
Other Costs																	
Total	\$0																
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0												

Total for Conference / Workshop Travel

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Travel between sites	300	\$0.560	\$168		\$168
			\$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

FORM I-3: EQUIPMENT Budget Category
Detail Form

Legal Name of Respondent:

0

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
Apple - 12.9-Inch iPad Pro (4th Generation) with Wi-Fi - 128GB; edge-to-edge Liquid Retina display with ProMotion, True Tone, and P3 wide color ¹ . A12Z Bionic chip with Neural Engine 12.0MP Wide camera, 10.0MP Ultra Wide camera, and LiDAR Scanner. 7.0MP TrueDepth front camera x 6	Patient Registration. Tracking and entering COVID19 immunization into ImmTrac2	6	\$999	\$5,994
LaptopDell - Latitude 7000 14" Laptop - Intel Core i7 - 16 GB Memory -		4	\$2,000	\$8,000
AED x 3	Emergency Preparedness	3	\$1,800	\$5,400
Connex ProBP 3400 Digital Blood Pressure Device x 7		3	\$628	\$1,884
				\$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:

\$21,278

FORM I-4: SUPPLIES Including CONTROLLED ASSETS Budget Category Detail Form

Legal Name of Respondent:

0

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 <small>[If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]</small>	Purpose & Justification	Total Cost
General Office Supplies	Paper, files, carrying case, pens, pencils etc	\$6,600
P/N VFC400-VMK Vaccine Monitoring Kit VFC400 Vaccine Monitoring Kit, includes: * (1) VFC400 Data Logger * (1) Two point (fridge/freezer) Two year NIST Traceable Certificate of Calibration, compliant to ISO/IEC 17025:2005 * (1) 3" Stainless, 1/8" OD Probe, with 5' sensor cable P/N SSP-0615 * (1) 30ml High density plastic (shatter proof) glycol buffer bottle P/N SPB-1019 * (1) Acrylic stand P/N AS-1031 * (1) Installation & Mounting Kit P/N IMK-1015 * (1) Wall mount bracket * (1) Extra replaceable battery * Control Solutions has a 2 year full warranty for the VFC400.	MONITOR Refrigerator TEMPERATURE QUANTITY 17 @ 139.65 EACH	\$2,374
Model: PR-TC14 (Portable) 13.51 Capacity cooling compartment. Dimensions: 12.9"H X 17.7W X 11.9D, Thermoelectric technology keeps content cold or warm for use with 12V power outlet. Lightweight design for easy portability, control and monitor the temperature via 1 7-stage setting, memory function remembers your preferences, eve	Transport Vaccine QUANTITY 4 @ \$650.00 EACH	\$2,600
STATA software	Public health practitioners statistical software	\$12,840

Emergency Response/Preparedness Kit x3 one for each COVID19 Vaccination Site	In the event of a medical emergency, the clinic sites will be prepared to provide emergency care for patients	\$3,600
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Supplies:

\$28,014

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: 0

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
ARCH	Buyout	Need to "buy out staff to support infrastructure x 1 staff	lump sum			\$5,000
Tryfacta	Buyout	Need to "buy out staff to support infrastructure x 1 staff	lump sum			\$5,040
ARCH	Buyout	Need to "buy out staff to support infrastructure x 1 staff	lump sum			\$5,000
Immunization Coordinator - LVN		Coordinates COVID19 immunization clinic. Ensuring the highest COVID19 immunization coverage rate possible for FBC. Supporting quality assurance and process to ensure vaccine viability and maintenance of cold chain of vaccine.	\$5280/month	6 months		\$31,680
					\$5,280.00	\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL:

\$46,720

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent:

0

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	Purpose & Justification	Total Cost
Hotspot Data Plan for Microsoft Office Surface Pad \$70 a month X 19	Access Immtrac offsite - @1,330 per year for 2 employees	\$2,660
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$2,660

FORM I - 7 Indirect Costs

Legal Name of Respondent:

0

Total amount of indirect costs allocable to the project:

Amount:

\$0

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:

_____ 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 FORMS INSTRUCTIONS

The budget templates (two per budget category) that follow are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template. Applicants that have utilized all the lines on the primary budget template must use the supplemental templates to list detail information for the respective budget category. For example, after all the lines on the primary budget template for Personnel (tab labeled Form I - 1 Personnel) have been used, go to the supplemental template labeled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labeled "Form I - 1b Personnel". The amounts on each supplemental template will automatically total and the total from both templates will automatically be inserted on the last line of the primary budget template.

The supplemental budget templates are:

- Form I-1 Personnel Supplemental
- Form I-2 Travel Supplemental
- Form I-3 Equipment Supplemental
- Form I-4 Supplies Supplemental
- Form I-5 Contractual Supplemental
- Form I-6 Other Supplemental

FORM I-1: PERSONNEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

0

PERSONNEL	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
Functional Title + Code E = Existing or P = Proposed							
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
SalaryWage Total							\$0

FORM I-1: PERSONNEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

0

PERSONNEL	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
Functional Title + Code E = Existing or P = Proposed							
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
SalaryWage Total							\$0

FORM I-2: TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

0

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)	Number of: Days/Employees	Travel Costs	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$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
			\$0		\$0

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

FORM I-2: TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

0

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)	Number of: Days/Employees	Travel Costs	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$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

FORM I-5: CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: 0

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
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0

Total Amount Requested for CONTRACTUAL: \$0

FORM I-5: CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent: 0

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
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0

Total Amount Requested for CONTRACTUAL: \$0

FORM I - 7 Indirect Costs

Legal Name of Respondent:

0

Total amount of indirect costs allocable to the project:

Amount:

\$0

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:

_____ 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.