FORM I: 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 Sources (5)	Other Funds **(6)**
A. Personnel	$180,351	$180,351	$0	$0	$0	$0
B. Fringe Benefits	$90,792	$90,792	$0	$0	$0	$0
C. Travel	$8,222	$8,222	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$9,587	$9,587	$0		$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$9,935	$9,935	$0	$0	$0	$0
H. Total Direct Costs	$298,887	$298,887	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0		$0	$0
J. Total (Sum of H and I)	$298,887	$298,887	$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**	**$180,351**	**$180,351**	**Fringe Benefits**	**$90,792**	**$90,792**
	Travel	**$8,222**	**$8,222**	**Equipment**	**$0**	**$0**
	Supplies	**$9,587**	**$9,587**	**Contractual**	**$0**	**$0**
	Other	**$9,935**	**$9,935**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$298,887**	**Budget Total**	**$298,887**

*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.

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 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 DSHS Contractors Financial Procedures Manual located at the following web site: http://www.dshs.state.tx.us/contracts/

FORM I-1: PERSONNEL Budget Category Detail Form

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

PERSONNEL Functional Title + Code 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
Disease Intervention Specialist (P)	Y	Conducts Field Investigations to provide disease intervention and field rapid tests for HIV and Syphilis, Partner Elicitation/notification	1	N/A	$4,000.00	9	$36,000
Disease Intervention Specialist (P)	Y	Conducts Field Investigations to provide disease intervention and field rapid tests for HIV and Syphilis, Partner Elicitation/notification	1	N/A	$4,000.00	9	$36,000
Senior Health Data Analyst (P)	Y	Increase capacity for community data management and analysis to inform public health interventions in the county with specifc focus on STI and other health disparities across communities	1	N/A	$6,335.34	9	$57,018
Program Manager (E)	Y	Oversees the program and clinical operations of the STI program & ensure that program is successfully implemented	0.8	RN	$7,129.60	9	$51,333
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$180,351

FRINGE BENEFITS	**Itemize the elements of fringe benefits in the space below:**
Fringe Benefits: Social Security - 7.65% ($13,797), Group Health - ($16,100 annually/FTE calculated to 9 months for 3.9 FTE = $45,885), Workers Compensation - 1.0% ($1,804), P&C - 2.8% ($5,050), Retirement - 13.45% ($24,257); TOTAL: $90,793	

	Fringe Benefit Rate %	50.34%
	Fringe Benefits Total	$90,792

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	
New Staff Training	Fundamental of Sexually Transmitted Disease Intervention Training. Three New staff required to attend as part of program requirements. Training dates and locations to be announced by DSHS for 3 Employees		3	Mileage	
				Airfare	$630
				Meals	
				Lodging	
				Other Costs	
				Total	$630
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	$0
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Revised: 7/6/2009

Total for Conference / Workshop Travel $630

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Reimbursable mileage for staff to conduct file work for DIS to conduct field visits and conduct partner services.	12978	$0.585	$7,592		$7,592
			$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 $7,592

Other / Local Travel Costs: $7,592 Conference / Workshop Travel Costs: $630 **Total Travel Costs:** $8,222

Indicate Policy Used: Respondent's Travel Policy State of Texas Travel Policy

Revised: 7/6/2009

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. 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
				$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: 7/6/2009

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
GC/CT Test Kits	GC/CT Point of Care Testing field - Average $10/test X 100 Kits. This contributes to the 10% allowable for diagnostic testing.	$1,000
Rapid Syphilis Tests Kits	Sypilis Point of Care Testing field - Average $10/test X 100 Kits. This contributes to the 10% allowable for diagnostic testing.	$1,000
Rapid HIV Test Kits	HIV Point of Care Testing field - Average $10/test X 100 Kits. This contributes to the 10% allowable for diagnostic testing.	$1,000
General Supplies (Support Clinic Operations)	Highlighters #2874483 ($6/Box X 5)	$30
	Paper - 10 Reams per case ($45/Case X 4Cases)	$180
	Pens #664011 ($8/Box X 5 Boxes)	$40
	Staplers #426487 ($26 Each X 3)	$78
	Staple Removers #908681 ($7/Each X 2)	$14
	Laminator #351655 ($32 Each X 1)	$32
	Laminating Sheets #801826 ($28/Pack X 2 Packs)	$56
	3 Hole Punch #908848 ($28 Each X 3)	$84
	Writing Pads #305706 ($15 Each X 8)	$120
	Dell 27 Monitor S2721D ($199.99 Each X 8)	$1,600
	Dell Docking Station WD19S 180W ($311.99 Each X 3)	$936
	Avery Binder Dividers Set of 6 #8364981 ($35.49/Pack X 3)	$106
	Post-it Notes #1230652 ($19/Pack X 6 Packs)	$114
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$3,197

Total Amount Requested for Supplies: **$9,587**

Revised: 7/6/2009

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
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						$0

Total Amount Requested for CONTRACTUAL: $0

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form

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

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	Purpose & Justification	Total Cost
Cellphone Wireless Services (Phone and WIFI Hotspot)	Wireless Services (Phone and WIFI Hotspot) Safety - maintain communication with staff and clients while out in the field. Provide mobile # to clients so they can reach DIS workers. ($75/Month x 3 FTEs X 9 Months)	$2,025
City of Houston Public Health Laboratory	Monthly service cost to provide diagnostic reports to rendering medical providers. ($850/Month X 9 Months)	$7,650
AllGeo	AllGeo Service provides real time alerts and notifications to help safely monitor field operation workers - Annual Subscription Fee (2 Employees) $240 + One Time Set up Fee ($10/Device X 2 Devices) $20 = $260	$260
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$9,935**

Revised: 7/6/2009

FORM I - 7 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 based on a rate proposal prepared in accordance with OMB Circular A-87. 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. The CFPM is available on the following internet web link: http://www.dshs.state.tx.us/contracts/

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 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 labled Form I - 1 Personnel) have been used, go to the supplemental template labled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labled "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: **Fort Bend County**

PERSONNEL Functional Title + Code 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
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$0

Revised: 7/6/2009

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

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

PERSONNEL Functional Title + Code 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
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$0

Revised: 7/6/2009

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

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	
				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
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0

Total for Conference / Workshop Travel $0

Revised: 7/6/2009

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

Revised: 7/6/2009

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

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	
				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
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0

Total for Conference / Workshop Travel $0

Revised: 7/6/2009

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

Revised: 7/6/2009

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Supplemental)

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

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
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0

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

Revised: 7/6/2009

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form (Supplemental)

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

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
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0

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

Revised: 7/6/2009

FORM I-4: SUPPLIES Budget Category Detail Form (Supplemental)

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 (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost
Dell Latitude 7420 Laptop x 2	Clinic operations , data entry, patient records ($ 1525 each)	$3,050
Sharpie Pens x2 boxes	Support clinic operations	$60
Pencils x 2 boxes	Support clinic operations	$37
Pencil sharpner x 2	suppot clinic operations	$50

Total Amount Requested for Supplies: **$3,197**

FORM I-4: SUPPLIES Budget Category Detail Form (Supplemental)

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 (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost

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

Revised: 7/6/2009

FORM I-5: 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 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

Total Amount Requested for CONTRACTUAL: $0

Revised: 7/6/2009

FORM I-5: 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 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

Total Amount Requested for CONTRACTUAL: $0

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form (Supplemental)

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

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

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

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form (Supplemental)

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

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

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

Revised: 7/6/2009