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	$630,039	$164,575	$0	$0	$465,464	$0
B. Fringe Benefits	$338,834	$93,462	$0	$0	$245,372	$0
C. Travel	$3,642	$300	$0	$0	$3,342	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$12,018	$27	$0	$0	$11,991	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$0	$0	$0	$0	$0	$0
H. Total Direct Costs	$984,533	$258,364	$0	$0	$726,169	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$984,533	$258,364	$0	$0	$726,169	$0
K. Program Income - Projected Earnings	$30,145	$7,911			$22,234	

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**	**$630,039**	**$630,039**	**Fringe Benefits**	**$338,834**	**$338,834**
	Travel	**$3,642**	**$3,642**	**Equipment**	**$0**	**$0**
	Supplies	**$12,018**	**$12,018**	**Contractual**	**$0**	**$0**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$984,533**	**Budget Total**	**$984,533**

*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.

TEXAS Department of State Health Services

FY2022

Applicant Information

Legal Name of Applicant Agency:	Fort Bend County
Mailing Address:	
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)**:**	746001969
DUNS # (9 digits required for subrecipient contractors)**:**	81497075

Type of Entity (Choose one)

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

Project Period

Start Date:	9/1/2022
End Date:	8/31/2023

Counties Served

County(ies) Served:	Fort Bend County
Amount of Funding Allocated:	$258,364.00

CONTACT PERSON INFORMATION

Legal Business Name: 0

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	Jacquelyn Minter-Johnson			Mailing Address (street, city, county, state, & zip):
Phone:		Ext:		4520 Reading Road Suite A-100 Rosenberg, Texas 77471
Fax:				
E-mail:	jacquelyn.minter@fortbendcountytx.gov			
B-13/FSR Rep:	Humera Ansari			Mailing Address (street, city, county, state, & zip):
Phone:	281-344-3978	Ext:		301 Jackson Street, Suite 701 Richmond, Texas 77469
Fax:				
E-mail:	humera.ansari@fortbendcountytx.gov			
IMM/LOCALS Program Leader:	Barbarah Martinez			Mailing Address (street, city, county, state, & zip):
Phone:	281-238-3548	Ext:		4520 Reading Road Suite A-200 Rosenberg, Texas 77471
Fax:				
E-mail:	barbarah.martinez@fortbendcountytx.gov			
IMM/LOCALS Coordinator:	Joyce Brown			Mailing Address (street, city, county, state, & zip):
Phone:	281-238-3552	Ext:		4520 Reading Road Suite A-200, Rosenberg, Texas 77471
Fax:				
E-mail:	joyce.brown@fortbendcountytx.gov			
Authorized Signatory for **DocuSign**	KP George			Mailing Address (street, city, county, state, & zip):
Phone:	281-341-8608	Ext:		301 Jackson Street Suite 701 Richmond, Texas 77469
Fax:	281-341-8609			
E-mail:	county.judge@fortbendcountytx.gov			
Additional Authorized Signatory for **DocuSign only if applicable (FFATA, Certs, etc)**	KP George			
Phone:	281-341-8608	Ext:		
Fax:	281-341-8609			
E-mail:	county.judge@fortbendcountytx.gov			
DocuSign "CC" Person				
Phone:		Ext:		
Fax:				
E-mail:				
Emergency Contact	Cynthia Smith			Mailing Address (street, city, county, state, & zip):
Cell Phone:	281-238-3558	Ext:		4520 Reading Road Suite A-200 Rosenberg Texas 77471
Fax:				
E-mail:	cynthia.smith@fortbendcountytx.gov			

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 locaated 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-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
Immunization Program Manager E=1	N	Oversees/ Provides Training and QI for/ Schedules/ Immunization Services	0.2	RN	$7,753.44	12	$18,608
Immunization Nurse E=4	N	Provide Immunization Services	1	LVN	$4,878.92	12	$58,547
Immunization Nurse P =1	Y	Provide Immunization Services	0	LVN	$4,878.92	12	$0
Community Service Aides E=4	N	Support Immunization Services	1	N/A	$2,672.64	12	$32,072
Clinical Health Division Manager E=1	N	Directs Immunization Program	0.01	APRN	$8,531.22	12	$1,024
IMMTRAC/ PIC/ VFC Outreach Specialist E=1	N	Provides Immtrac and VFC activity support	1	N/A	$4,344.78	12	$52,137
IMMTRAC/ PIC/ VFC Outreach Specialist P=1	Y	Provides Immtrac and VFC activity support	0	N/A			$0
Administrative Assistant E=1	N	Process Immunizations Payroll, Accounts Payable, Purchasing of Supplies, Arrange Travel/ Training for staff	0.05	N/A	$3,645.30	12	$2,187
							$0
							$0
							$0
							$0
							$0
					TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS		$0
					SalaryWage Total		$164,575

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

FICA =7.65%, Retirement =13.45%, WC/Unemp =1.00%, P & C =2.8%, Health Insurance 16100/FTE/year

Fringe Benefit Rate %	56.79%

Revised: 7/6/2009

	Fringe Benefits Total	$93,462

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	
				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 FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Revised: 7/6/2009

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)
Travel between locations and for required site visits	512	$0.585	$300		$300
			$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 $300

Other / Local Travel Costs: $300 Conference / Workshop Travel Costs: $0 **Total Travel Costs:** $300

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

FORM I-3: EQUIPMENT 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
	TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS			$0

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

Revised: 7/6/2009

FORM I-4: SUPPLIES Including CONTROLLED ASSETS Budget Categor

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.** Pr
Costs may be categorized by each general type (e.g., office, computer, medical, educational, etc.) See attached example for defini
to complete this form.

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification
Ball point pens PaperMate Profile	Office supplies to assist with clilnic workflow
Removable Round Color Coding Labels Assorted Colors	Office supplies to assist with clilnic workflow
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	

Total Amount Requested for Supplies:

/ Detail Form

ovide a justification for each supply item.
tion of supplies and detailed instructions

Total Cost
$16
$11
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0

$27

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
		$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: **$0**

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:** **$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.	

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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 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 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-4: SUPPLIES including CONTROLLED ASSETS Budget Category Detail Fo

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** 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 Amount Requested for Supplies:

rm (Supplemental)

. Provide a justification for each

Total Cost

$0

FORM I-4: SUPPLIES including CONTROLLED ASSETS Budget Category Detail Fo

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** 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 Amount Requested for Supplies:

e. Provide a justification for each

Total Cost

$0

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

FORM I - 7 Indirect Costs

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

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.	

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