

## **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: BUDGET SUMMARY (REQUIRE

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Progr

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)
A. Personnel	\$117,580	\$117,580	\$0	\$0
B. Fringe Benefits	\$39,965	\$39,965	\$0	\$0
C. Travel	\$10,641	\$10,641	\$0	\$0
D. Equipment	\$3,047	\$3,047	\$0	\$0
E. Supplies	\$25,079	\$25,079	\$0	\$0
F. Contractual	\$0	\$0	\$0	\$0
G. Other	\$3,688	\$3,688	\$0	\$0
H. Total Direct Costs	\$200,000	\$200,000	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$200,000	\$200,000	\$0	\$0
K. Program Income - Projected Earnings	\$200,000	\$200,000		

**NOTE: The "Total Budget" amount for each Budget Category will have to be allocated (entered) from various sources. Enter amounts in whole dollars. After amounts have been entered for each funding source, the "Total" below equals the respective amount under the "Total Budget" from column (1).**

	Budget Category	Distribution Total	Budget Total	Budget Category
<b>Check Totals For:</b>	<b>Personnel</b>	<b>\$117,580</b>	<b>\$117,580</b>	<b>Fringe Benefits</b>
	<b>Travel</b>	<b>\$10,641</b>	<b>\$10,641</b>	<b>Equipment</b>
	<b>Supplies</b>	<b>\$25,079</b>	<b>\$25,079</b>	<b>Contractual</b>
	<b>Other</b>	<b>\$3,688</b>	<b>\$3,688</b>	<b>Indirect Costs</b>

<b>TOTAL FOR:</b>	<b>Distribution Totals</b>	<b>\$200,000</b>	<b>Budget Total</b>
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\*Letter(s) of good standing that validate the respondent's programmatic, administrative, and financial capabilities. If the respondent receives any funding from state agencies other than DSHS related to this project. If the respondent has a higher education, letter(s) of good standing are not required. DO NOT include funding from other state agencies in column 3 that is not related to activities being funded by this DSHS project.

**D)**

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Local Funding Sources (5)	Other Funds (6)
\$0	\$0
\$0	\$0
\$0	\$0
\$0	\$0
\$0	\$0
\$0	\$0
\$0	\$0
\$0	\$0
\$0	\$0
\$0	\$0
\$0	\$0

annually among the funding  
 source, verify that the "Distribution

Distribution Total	Budget Total
\$39,965	\$39,965
\$3,047	\$3,047
\$0	\$0
\$0	\$0

**\$200,000**

ability must be placed after this form if  
 applicant is a state agency or institution of  
 higher learning or other agencies in column 4 or Federal sources





## FORM I-2: TRAVEL Budget Category Detail F

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

Conference / Workshop Travel Costs			
Description of Conference/Workshop	Justification	Location City/State	N Days
Lactation Support Quartely Meeting x every 3 months	Directors from Lactation Support Meeting meet quartely to discuss updates at the LSC.	Austin ,Tx	
Breastfeeding Outlook 90 hour Core Concept course, Dallas, Texas	For RN to obtain her 90 hrs to take her IBCLC Exam and be able to assist at Lactation Care Center	Dallas, Tx	
ILCA 2020 Conference	For the RN Supervisor and IBCLC to attend the 2020 ILCA Conference in Houston, Tex. July 8-11, 2020	Houston ,Tx	
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDG			

**Total for Conference /**

Other / Local Travel Costs				
Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Ot
Travel to do Dr's Office, Hospitals, Community Center's or Clinic's, or other health professional facility who care for women, infant and children. Also, reach out to clients who have the lack of transportation and cannot go to the Lactation Support Center for services, on their behalf. Our main goal is to service our clients.	1983	\$0.580	\$1,150	

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

TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDG

**Total for C**

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

Indicate Policy Used:

Respondent's Travel Policy

**Form**

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Number of:	Travel Costs	
Days/Employees		
3/1	Mileage	
	Airfare	\$1,497
	Meals	\$297
	Lodging	\$756
	Other Costs	\$300
	<b>Total</b>	<b>\$2,850</b>
4/1	Mileage	\$0
	Airfare	\$800
	Meals	\$195
	Lodging	\$800
	Other Costs	\$2,492
	<b>Total</b>	<b>\$4,287</b>
4/2	Mileage	
	Airfare	\$900
	Meals	\$312
	Lodging	\$800
	Other Costs	\$342
	<b>Total</b>	<b>\$2,354</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
GET SHEETS		\$0

**Workshop Travel**      **\$9,491**

Other Costs (b)	Total (a) + (b)
\$0	\$1,150

	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
3ET SHEETS	\$0

Other / Local Travel

**Total Travel Costs:**

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State of Texas Travel Policy



# Category

definition and detailed instructions to complete this

Number of Units	Cost Per Unit	Total
2	\$1,320	\$2,640
2	\$99	\$198
2	\$105	\$209
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
.EMENTAL BUDGET SHEETS		\$0

Equipment: **\$3,047**

## FORM I-4: SUP

**Legal Name of Respondent:**

Itemize and describe each supply item and **provide an estimated quantity and cost** be categorized by each general type (e.g., office, computer, medical, educational)

Description of Item <small>[If applicable, provide estimated quantity and cost (i.e. # of boxes &amp; cost/box)]</small>
Item: 17450 Dual Hygienikit Custom Flange System Sterile 250x 40.42 = \$10,105.00
Item: 67218 Kit 20mm Nipple Shield 6/cs. 32.00 x 20cs= 640.00
Item: 974808 Tube, Feeding Ped PVC STR 8FR 16" 50/CS, \$111.49x15/cs=\$ 1672.35
Item: 928732 Wipe, SaniCloth Super Germicide Lg (160/cn 12cn/cs \$7.86 x 60= \$472.00
Item: 562037 Dispenser Purell TFX Gry TCH Free (12 cs/\$175.17
Item: 559814 Sanitizer Gentle Foam 1200ML Refill (CS/2 \$59.49 x30= \$1784.70
Item: 826199 Surface Disinfectant CaviWipes 1 Premoistened Wipe 160 Count Canister Disposable Alchol Scent. CN/160 10.86X 200= \$2,172
Item: 194631 Disinfectant Cavicide GI MX- 1000 Gal. 50 x \$26.93= \$1346.50
Item: N21500 Brown Multifold Towels 400/cs \$14.80 /cs x 40= \$592
Item: TJ1222A SCA Sr Jumbo Tissue 80/550 20 x 38.07= \$ 761.40
Item: K21340 Surpass Facial Tissue 30/100) 5x25.20= 126.00
Item: PF202 2 - Pocket Folder Lactation Logo 550x\$1.81= \$994.51 Shipping included
Item: 567 Pens with Lactation Center Logo 2000 x .45= \$900.00 Shipping included
Item: 90502 The Rewards of Breastfeeding Poster Set Poster Set (4) \$61.00 x 4 + Shipping= \$255.79
Item: Pop 3 Socket with Lactation Logo 2000 x \$.79= \$1580.00 Shipping included
Item: DMF Dust Mop Frame 3x 3.00= \$9.00

# PLIES Budget Category Detail Form

**Hidalgo County Health and Human Services WIC Program**

Quantity and cost (i.e. #of boxes & cost/box) if applicable. Provide a justification for each supply item. Costs may vary (educational, etc.) See attached example for definition of supplies and detailed instructions to complete this form.

Purpose & Justification	Total Cost
Dual Hygienikit Custom are provided to the Non WIC Moms who have infants in the hospital with infants who have special need	\$10,105
Help Non WIC that are having latching on problems upon release from hospitals	\$640
To help newborns who are having breastfeeding problems	\$1,673
To clean the multiusers that are at the Lactation Center.	\$472
To install in the consultation rooms to prevent germs from spreading, and keep rooms well sanitize.	\$175
To install in the consultation rooms to prevent germs from spreading, and keep rooms well sanitize.	\$1,785
A multipurpose disinfectant / decontaminate wipe, can be used on hard porous surface 1 minute contact time for virucidal, bactericidal including TB, fungicidal activity 1 step cleaner and disinfectant. To be used in the seating chairs and seating couches where BF Mom come into the rooms with their infants.	\$2,172
To clean and maintain rooms patient care effectively clean	\$1,347
To be used in the bathrooms and rooms	\$592
To be used in the bathrooms and rooms	\$761
To be at the Lactation Center	\$126
Outreach presentation for the Lactation Center	\$995
Outreach presentation for the Lactation Center	\$900
For the Breastfeeding Rooms at Lactation Center.	\$256
Outreach presentation for the Lactation Center	\$1,580
To maintenance Lactation Center clean	\$9
<b>TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS</b>	<b>\$1,492</b>

**Total Amount Requested for Supplies:**

**\$25,079**

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## FORM I-5: CONTRACTUAL Budget Category Detail F

Legal Name of Respondent: **Hidalgo County Health and Human Services WIC Program**

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 as "Service to be provided by a third party, name 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 a

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., Monthly, Hourly, Unit, Lump Sum)
TOTAL FROM CONTRACTUAL SUP			

**Total Amount Requested**



# FORM I-6: OTI

Legal Name of Respondent:

<b>Description of Item</b> [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]
Annual Renewal Mobile Lactation Grade plan for the Ipads that is due yearly. 1 x \$1,188.00
Printing of Resource information such as pamphlets, handouts, business cards

# HER Budget Category Detail Form

**Hidalgo County Health and Human Services WIC Program**

Purpose & Justification	Total Cost
This plan is used by the Staff at the Lactation Care Center which they input the client information, lactation vist's, concerns. This is an electronic medical record program that is used on the iPads at the Lactation Support Center.	\$1,188
Printing of handouts for the Lactation Center that are used for outreach	\$2,500
	\$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:** **\$3,688**

# FORM I - 7 Indirect Costs

Legal Name of Respondent:

Hidalgo 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.**

**RATE:**

**TYPE:**

**BASE:**

\_\_\_\_\_ **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.

\_\_\_\_\_ 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)**

**Page 2, FORM I - 7 Indirect C**

If using an central service or indirect cost rate, identify the types of costs that are included (I

Organizations that do not use an indirect cost rate and governmental entities with only a central service allocated as indirect costs and the methodology used to allocate these costs in the space provided in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the type of indirect cost, the allocation methodology, and the allocation base:**

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**Health and Human Services WIC Program**

**\$0**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Costs**

\_\_\_\_\_

being allocated) in the rate:

price rate must identify the types of costs that will be below. The costs/methodology must also be disclosed in **types of costs that are being allocated as 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-2: TRAVEL Budget Category Detail Form (S**

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

**Conference / Workshop Travel Costs**

Description of Conference/Workshop	Justification	Location (City, State)

**Total for Conference**

**Other / Local Travel Costs**

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)
			\$0
			\$0
			\$0

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

**Total fo**

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

**Supplemental)**

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Number of: Days/Employees	Travel Costs	
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>

**/ Workshop Travel** **\$0**

Other Costs (b)	Total (a) + (b)
	\$0
	\$0
	\$0

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

r Other / Local Travel

**Total Travel Costs:**

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

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

### Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)

**Total for Conference**

### Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)
			\$0
			\$0
			\$0

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

**Total fo**

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

**Supplemental)**

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Number of: Days/Employees	Travel Costs	
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>
	Mileage	
	Airfare	
	Meals	
	Lodging	
	Other Costs	
	<b>Total</b>	<b>\$0</b>

**/ Workshop Travel** **\$0**

Other Costs (b)	Total (a) + (b)
	\$0
	\$0
	\$0

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

r Other / Local Travel

**Total Travel Costs:**

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# Budget Category Detail Form (Supplemental)

**Hidalgo County Health and Human Services WIC Program**

Quantity and cost (i.e. # of boxes & cost/box) if applicable. Provide a justification for each supply item. Costs may include incentives, educational, etc.)

Purpose & Justification	Total Cost
Replacement Ink Cartridge for RN IBCLC Printer which she uses to do presentations for training's held at LSC	\$208
Replacement Ink Cartridge for RN IBCLC Printer which she uses to do presentations for trainings at the LSC	\$348
Replacement Ink Cartridge for RN IBCLC Printer which she uses to do presentations for trainings at the LSC	\$251
Replacement Ink Cartridge for RN IBCLC Printer which she uses to do presentations for trainings at the LSC	\$251
Educational Posters of 10 Steps of Breastfeeding that need frames so they can be installed at the LSC	\$120
Item that will be used for outreach for the LSC	\$314

**Total Amount Requested for Supplies:** **\$1,492**







**Supplemental)**

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Price to be contracted and show contractors as "To Be Attached behind this form.

# 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

for CONTRACTUAL: 

	\$0
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**Supplemental)**

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Price to be contracted and show contractors as "To Be Attached behind this form.

# 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

for CONTRACTUAL: 

	\$0
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