

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:

Hidalgo County Health and Human Services WIC Program

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds*	Local Funding Sources (5)	Other Funds (6)
A. Personnel	\$323,726	\$135,310	\$0	\$188,416	\$0	\$0
B. Fringe Benefits	\$120,519	\$47,832	\$0	\$72,687	\$0	\$0
C. Travel	\$6,672	\$3,336	\$0	\$3,336	\$0	\$0
D. Equipment	\$0	\$0	\$0	\$0	\$0	\$0
E. Supplies	\$13,047	\$13,047	\$0	\$0	\$0	\$0
F. Contractual	\$0	\$0	\$0	\$0	\$0	\$0
G. Other	\$475	\$475	\$0	\$0	\$0	\$0
H. Total Direct Costs	\$464,439	\$200,000	\$0	\$264,439	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$464,439	\$200,000	\$0	\$264,439	\$0	\$0
K. Program Income - Projected Earnings	\$0	\$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	\$323,726	\$323,726	Fringe Benefits	\$120,519	\$120,519
	Travel	\$6,672	\$6,672	Equipment	\$0	\$0
	Supplies	\$13,047	\$13,047	Contractual	\$0	\$0
	Other	\$475	\$475	Indirect Costs	\$0	\$0

TOTAL FOR:	Distribution Totals	\$464,439	Budget Total	\$464,439
-------------------	----------------------------	------------------	---------------------	------------------

*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:

Hidalgo County Health and Human Services WIC Program

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
Registered Nurse Consultant (E)	N	To serve Non WIC & WIC participants at the Lactation Center	0.5	RN, IBCLC	\$7,933.54	12	\$47,601
PEER Counselor I (P)	N	Assist RN at Lactation Center servicing Non WIC & WIC participants	0.2	NA	\$2,318.82	12	\$5,565
PEER Counselor II (P)	N	Assist RN at Lactation Center servicing Non WIC & WIC participants	0.2	NA	\$2,423.58	12	\$5,817
International Board Certified Lactation Consultant (P)	N	To serve Non WIC & WIC participants at the Lactation Center	0.4	IBCLC	\$3,794.83	12	\$18,215
International Board Certified Lactation Consultant (E)	N	To serve Non WIC & WIC participants at the Lactation Center	0.4	IBCLC	\$4,105.46	12	\$19,706
Registered Nurse Consultant (E)	N	To serve Non WIC & WIC participants at the Lactation Center	0.5	RN, IBCLC	\$6,400.95	12	\$38,406
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							\$0

SalaryWage Total **\$135,310**

FRINGE BENEFITS	Itemize the elements of fringe benefits in the space below:
Health Insurance = \$251.05 x 12 X 6 = \$18,075	FICA - 7.65% = \$10,351 Unemployment Comp. - 0.60% = \$812
Life Insurance = \$1.33 x 12 x 6 = \$96	Retirement - 12.73% = \$17,225 Workers Comp. - .94% = \$1,272
Fringe Benefit Rate % 35.35%	
Fringe Benefits Total \$47,832	

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

Conference / Workshop Travel Costs						
Description of Conference/Workshop	Justification	Location City/State	Number of:		Travel Costs	
			Days/Employees			
Attend the Texas WIC Lactation Support Quarterly Meeting in Austin, Texas which is done quarterly	Attend the quarterly meeting to discuss LSC updates, General Updates from LSC Managers, and discuss updates on charting, Telconsults.	Austin, Tx	2	1	Mileage	
					Airfare	\$619
					Meals	\$78
					Lodging	\$365
					Other Costs	\$50
					Total	\$1,112
Attend the Texas WIC Lactation Support Quarterly Meeting in Austin, Texas which is done quarterly	Attend the quarterly meeting to discuss LSC updates, General Updates from LSC Managers, and discuss updates on charting, Telconsults.	Austin, Tx	2	1	Mileage	
					Airfare	\$619
					Meals	\$78
					Lodging	\$365
					Other Costs	\$50
					Total	\$1,112
Attend the Texas WIC Lactation Support Quarterly Meeting in Austin, Texas which is done quarterly	Attend the quarterly meeting to discuss LSC updates, General Updates from LSC Managers, and discuss updates on charting, Telconsults.	Austin, Tx	2	1	Mileage	
					Airfare	\$619
					Meals	\$78
					Lodging	\$365
					Other Costs	\$50
					Total	\$1,112
					Mileage	
					Airfare	
					Meals	
					Lodging	
					Other Costs	
					Total	\$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0	

Total for Conference / Workshop Travel

\$3,336

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
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-4: SUPPLIES Including CONTROLLED ASSETS Budget Category Detail Form

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

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
Item: 17450 Dual Hygienikit Custom Flange System Sterile, 50 @ \$18.25	Dual Hygienikit Custom are provided to the Non WIC Moms who have infants in the hospital with infants who have special need	\$913
Item: 880563 Wipe, Germicide LG 6"x6.75" (160/BX 12BX/CS) 2 cases @ \$87.96	To clean the multiusers that are at the Lactation Center.	\$176
Item: 194631 Disinfectant Surface Med Cavicide 1 gallon Ea, 4 ea/ca, 1 @ \$158.76 plus \$10 Shipping	To clean and disinfect breast pumps, clinic countertops, surfaces and scales	\$646
Item: 1057986 - Macbeth Large Polypropylene Tote, Solid Tan (25435-FEJ), 8 @ \$10.00	To store teaching models in orderly manner	\$80
Item: 1058076 - Macbeth Medium Polypropylene Tote, Solid Tan (25434-FEJ), 20 @ \$8.00	To store teaching models in orderly manner	\$160
Item: 264904 - X-ACTO Commercial Grade 15" Guillotine Trimmer, Black/Brown (26615), 1 @ \$203.88	To cut paper	\$204
Item: 386312 - Swingline Heavy Duty Desktop Stapler, 160 Sheet Capacity, Black/Gray (39005), 1 @ \$38.82	To staple end of year reports and other large stacks	\$39
Items: 793745 - Staples Thermal Pouches, Business Card, 25/Pack (17470), 12 @ \$3.04	To laminate promotional cards to use as ID badge companion	\$36
Essential Lactation Simulation Model, Skin Tone B, 2 @ \$990.00	To provide simulation training for nursing staff, residents, clients	\$1,980
Advanced Lactation Simulation Model, Skin Tone C, 2 @ \$990.00	To provide simulation training for nursing staff, residents, clients	\$1,980

NORAL Simulation Model - Baby, Skin Tone TBD, 4 @ \$1,140.00	To provide simulation training for nursing staff, residents, clients	\$4,560
Filling Fluids Refills, 7 @ \$20.00 plus 1 @ \$195.00 shipping cost	To provide simulation training for nursing staff, residents, clients	\$335
Breastfeeding What's a Dad supposed to do? ENGLISH DVD, 1 @ \$59.00	to teach fathers to support breastfeeding in our prenatal "Dad's" ENGLISH class.	\$59
Breastfeeding What's a Dad supposed to do? SPANISH DVD, 1 @ \$59.00	to teach fathers to support breastfeeding in our prenatal "Dad's" SPANISH class.	\$59
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$1,820

Total Amount Requested for Supplies:

\$13,047

FORM I-5: CONTRACTUAL Budget Category Detail Form

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 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

FORM I - 7 Indirect Costs

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

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.

 x 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:

Hidalgo County Health and Human Services WIC Program

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:

Hidalgo County Health and Human Services WIC Program

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:

Hidalgo County Health and Human Services WIC Program

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)	Number of: Days/Employees	Travel Costs												
				<table border="1" style="width: 100%; border-collapse: collapse;"> <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 style="text-align: right;">Total</td><td style="text-align: right;">\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		Total	\$0
Mileage																
Airfare																
Meals																
Lodging																
Other Costs																
Total	\$0															
				<table border="1" style="width: 100%; border-collapse: collapse;"> <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 style="text-align: right;">Total</td><td style="text-align: right;">\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		Total	\$0
Mileage																
Airfare																
Meals																
Lodging																
Other Costs																
Total	\$0															
				<table border="1" style="width: 100%; border-collapse: collapse;"> <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 style="text-align: right;">Total</td><td style="text-align: right;">\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		Total	\$0
Mileage																
Airfare																
Meals																
Lodging																
Other Costs																
Total	\$0															
				<table border="1" style="width: 100%; border-collapse: collapse;"> <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 style="text-align: right;">Total</td><td style="text-align: right;">\$0</td></tr> </table>	Mileage		Airfare		Meals		Lodging		Other Costs		Total	\$0
Mileage																
Airfare																
Meals																
Lodging																
Other Costs																
Total	\$0															
				<table border="1" style="width: 100%; border-collapse: collapse;"> <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 style="text-align: right;">Total</td><td style="text-align: right;">\$0</td></tr> </table>	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-2: TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

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: **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 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**

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

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 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**

