

## 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* (4)	Local Funding Sources (5)	Other Funds (6)
A. Personnel	\$134,602	\$134,602	\$0	\$0	\$0	\$0
B. Fringe Benefits	\$50,126	\$50,126	\$0	\$0	\$0	\$0
C. Travel	\$0	\$0	\$0	\$0	\$0	\$0
D. Equipment	\$0	\$0	\$0	\$0	\$0	\$0
E. Supplies	\$5,724	\$5,724	\$0	\$0	\$0	\$0
F. Contractual	\$0	\$0	\$0	\$0	\$0	\$0
G. Other	\$9,548	\$9,548	\$0	\$0	\$0	\$0
H. Total Direct Costs	\$200,000	\$200,000	\$0	\$0	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$200,000	\$200,000	\$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
<b>Check Totals For:</b>	Personnel	\$134,602	\$134,602	Fringe Benefits	\$50,126	\$50,126
	Travel	\$0	\$0	Equipment	\$0	\$0
	Supplies	\$5,724	\$5,724	Contractual	\$0	\$0
	Other	\$9,548	\$9,548	Indirect Costs	\$0	\$0

<b>TOTAL FOR:</b>	Distribution Totals	\$200,000	Budget Total	\$200,000
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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:

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

<b>PERSONNEL</b>	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							
Registered Nurse Consultant (E)	N	LSCS-SEP Coordinator / To serve Non WIC participants at the Lactation Center. Due to changes in the parent agency salary schedule.	0.5	RN, IBCLC	\$8,557.00	12	\$51,342
PEER Counselor I (E)	N	Assist RN at Lactation Center servicing Non WIC participants	0.2	NA	\$2,484.00	12	\$5,962
PEER Counselor II (E)	N	Assist RN at Lactation Center servicing Non WIC participants	0.2	NA	\$2,504.00	12	\$6,010
International Board Certified Lactation Consultant (E)	N	To serve Non WIC participants at the Lactation Center	0.5	IBCLC	\$3,968.00	12	\$23,808
Registered Dietitian IBCLC (E)	N	To serve Non WIC participants at the Lactation Center	0.3	RD, IBCLC	\$4,919.00	12	\$17,708
Registered Dietitian IBCLC (E)	N	To serve Non WIC participants at the Lactation Center	0.5	RD, IBCLC	\$4,962.00	12	\$29,772
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
<b>TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS</b>							<b>\$0</b>
<b>SalaryWage Total</b>							<b>\$134,602</b>

<b>FRINGE BENEFITS</b>	Itemize the elements of fringe benefits in the space below:	
Health Insurance = \$279x 12 X 6 = \$20,088.00	FICA - 7.65% = \$10,297.00	Unemployment Comp. - 0.60% =808.00
Life Insurance = \$1.72 x 12 x 6 = \$124.00	Retirement - 13.03% = \$17,538.00	Workers Comp. - 0.94% = 1,266.00
<b>Fringe Benefit Rate %</b>		<b>37.24%</b>

	<b>Fringe Benefits Total</b>	<b>\$50,126</b>
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## FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

<b>Conference / Workshop Travel Costs</b>					
Description of Conference/Workshop	Justification	Location City/State	Number of:		Travel Costs
				Days/Employees	
					Mileage
					Airfare
					Meals
					Lodging
					Other Costs
					<b>Total</b>
					Mileage
					Airfare
					Meals
					Lodging
					Other Costs
					<b>Total</b>
					Mileage
					Airfare
					Meals
					Lodging
					Other Costs
					<b>Total</b>
					Mileage
					Airfare
					Meals
					Lodging
					Other Costs
					<b>Total</b>
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)
			\$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 &amp; cost/box)]</small>	Purpose & Justification	Total Cost
Item: 17450 Dual Hygienikit Custom Flange System Sterile 150 @ \$18.25	To loan multi-user pump when indicated	\$2,738
Dual Pack Flexishield Areola Stimulator 21.0 mm 17212 pairs, 150 @ \$11.01 ea	for flange fitting smaller nipples	\$1,652
22.5 mm reducing Inserts 10011 1 ea 10/ca 15 cases @ \$18.70	for flange fitting smaller nipples	\$281
McKesson Neonatal / Pediatric Nasogastric Feeding Tube Kangaroo™ 6.5 Fr. 20 Inch Tube Polyurethane Sterile 1032453 50/ca 4 ca@150.79+ shipping \$20.00	to supplement at the breast when infant not transferring appropriately or client is not producing enough breast milk.	\$623
McKesson 60 mL Syringe 988343 50/ca 4 ca @ \$48.76 + shipping \$20.00	to aid in supplementing at the breast when infant not transferring appropriately or client is not producing enough breast milk.	\$215
Ameda MinFil 50 mL 800H01 200/ca 3 @72.00	to store expressed breast milk	\$216
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Supplies:

**\$5,724**

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

Total Amount Requested for CONTRACTUAL: \$0

## FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

Description of Item <small>[If applicable, include quantity and cost/quantity (i.e. # of units &amp; cost per unit)]</small>	Purpose & Justification	Total Cost
Rent, yearly amount of \$38,940; 21% will be paid with this grant.	To pay 21 percent of the buidling's rent	\$8,356
Annual Renewal Mobile Lactation Grade plan for the Ipads that is due yearly. 1 x \$1,188.00	This plan is used by the Staff at the Lactation Care Center which they input the client information, lacatation vist's, concerns. This is an electronic medical record program that is used on the iPads at the Lactation Support Center.	\$1,192
		\$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:

<b>\$9,548</b>
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# 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.

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

<b>PERSONNEL</b>	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
<b>SalaryWage Total</b>							<b>\$0</b>

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

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

<b>PERSONNEL</b>	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
<b>SalaryWage Total</b>							<b>\$0</b>

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

Legal Name of Respondent:

Hidalgo County Health and Human Services WIC Program

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

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

**Total Travel Costs:**

## 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	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	\$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-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
						\$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



