TEXAS Department of State Health Services

Division for Regional and Local Health Services

FY 2011 Local Public Health Services

FORM A - FACE PAGE

This form requests basic information about the respondent and project, including the signature of the authorized representative.

RESPONDENT INFORMATION

1) LEGAL NAME: Fort Bend County Clinical Health Services

2) MAILING Address Information (include mailing address, street, city, county, state and zip code):

4520 Reading Road, Ste. A
Rosenberg, TX 77471

3) PAYEE Mailing Address (if different from above):

Fort Bend County Auditor
301 Jackson Street, Ste. 533
Richmond, TX 77469

4) Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or if an individual, Social Security Number (9 digit) : 746001969

*The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.

5) TYPE OF ENTITY (check all that apply):

- ☐ City
- ☒ Regions/Counties/LHD
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith-based Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

*If incorporated, provide 10-digit charter number assigned by Secretary of State:

6) COUNTIES OR REGION SERVED BY PROJECT: Fort Bend County
See attached County/Region list.

7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: Nancy Drake R.N. Phone: 281-238-3548 Fax: 281-342-7371 E-mail: Nancy.drake@co.fort-bend.tx.us	☐ LPHS $ 34,681.00

The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications attached in FORM E, and will provide services in accordance with 25 Texas Administrative Code, §§37.51-37.65. This document has been duly authorized by the governing body of the applicant and I (the person signing below) am authorized to represent the applicant.

8) AUTHORIZED REPRESENTATIVE	9) SIGNATURE OF AUTHORIZED REPRESENTATIVE
Name: Robert E. Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-8609 E-mail: werleann@co.fort-bend.tx.us	10) DATE

*Form A – FACE PAGE must be faxed with signature to (512) 458 7154

Division for Regional and Local Health Services
FY 2011 Local Public Health Services
Program Contact Information
Contract Term: September 1, 2010 through August 31, 2011

Legal Name of Applicant: Fort Bend County Clinical Health Services

This form provides information about appropriate program contacts in the applicant's organization. If any of the contact information changes during the term of the contract, please send written notification to Regional and Local Health Service, 1100 W. 49th Street, T608, Austin, TX 78756, or email to LocalPHTeam@dshs.state.tx.us .

Director

Contact:	Jean N. Galloway, MD	**Mailing Address (street, city, county, state, & zip):**
Title:	Director, Fort Bend County HHS	4520 Reading Rd., Ste. A
Phone:	281-238-3223	Rosenberg
Fax:	281-238-3355	Fort Bend County
E-mail:	Jean.Galloway@co.fort-bend.tx.us	TX, 77471

Financial Manager

Contact:	Robert Sturdivant	**Mailing Address (street, city, county, state, & zip):**
Title:	County Auditor	309 4th Street, Suite 533
Phone:	281-341-3760	Richmond
Fax:	281-341-3774	Fort Bend County
E-mail:	Robert.Sturdivant@co.fort-bend.tx.us	TX, 77469

Contract Coordinator

Contact:	Nancy Drake, RN	**Mailing Address (street, city, county, state, & zip):**
Title:	Director, FBC Clinical Health Services	4520 Reading Rd., Ste. A
Phone:	281-238-3548	Rosenberg
Fax:	281-342-7371	Fort Bend County
E-mail:	Nancy.Drake@co.fort-bend.tx.us	TX, 77471

Additional Staff

Contact:	Kaye Reynolds, MPH	**Mailing Address (street, city, county, state, & zip):**
Title:	Deputy Director, FBC Health & Human Services	4520 Reading Rd., Ste. A
Phone:	281-238-3519	Rosenberg
Fax:	281-238-3355	Fort Bend County
E-mail:	Kaye.Reynolds@co.fort-bend.tx.us	TX, 77471

Additional Staff

Contact:		**Mailing Address (street, city, county, state, & zip):**
Title:		
Phone:		
Fax:		
E-mail:		

EXHIBIT A

Texas Department of State Health Services
Local Health Department: Fort Bend County Clinical Health Services
FY 2011 Request for Local Public Health Services Funds
Project Service Delivery Plan
Contract Term: September 1, 2010 through August 31, 2011

Indicate in this plan how requested Local Public Health Services (LPHS) contract funds will be used to address a public health issue through essential public health services. The plan should include a brief description of the public health issue(s) or public health program to be addressed by LPHS funded staff, and measurable objective(s) and activities for addressing the issue. List only public health issues/programs, objectives and activities conducted and supported by LPHS funded staff. List at least one objective and subsequent required information for each public health issue or public health program that will be addressed with these contract funds. The plan must also describe a clear method for evaluating the services that will be provided, including identification of a specific evaluation standard, as well as recommendations or plans for improving essential public health services delivery based on the results of the evaluation. Complete the table below for each public health issue or public health program addressed by LPHS funded staff. (Make additional copies of the table as needed)

Public Health Issue: ***Briefly describe the public health issue to be addressed. Number issues if more than one issue will be addressed.***
Fort Bend County has a growing population, topping half a million by latest estimates. This growth is bringing an ever increasing number of medical facilities and practitioners. Encouraging timely, complete and accurate reporting of reportable conditions, in order to monitor the health of the community and identify health problems that could be addressed, is an increasing burden to the staff of clinical Health Services.

Essential Public Health Service(s): ***List the EPHS(s) that will be provided or supported with LPHS Contract funds***
(A) monitor the notifiable conditions present in the community in order to identify community health problems and provide information needed to determine potential public health interventions

Objective(s): ***List at least one measurable objective to be achieved with resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc.)***
Enter complete information on notifiable conditions into the Texas Department of State Health Services NEDSS system

Performance Measure: ***List the performance measure that will be used to determine if the objective has been met. List a performance measure for each objective listed above.***
A report of all communicable diseases reported to the Texas Department of State Health Services during the grant period will be made. This report will include measures taken to ensure completeness and accuracy of reporting.

Activities *List the activities conducted to meet the proposed objective. Use numbering system to designate match between issues/programs and objectives.*	**Evaluation and Improvement Plan** *List the standard and describe how it is used to evaluate the activities conducted. This can be a local, state or federal guideline.*	**Deliverable** *Describe the tangible evidence that the activity was completed.*
1. Enter all reported cases into the NEDSS system for reporting to the Texas Department of State Health Services.	Activities under this program will be guided by the Texas Administrative Code, Title 25: Health Services, Part 1: Department of State Health Services, Chapter	1. Database of notifiable conditions in the NEDSS system.

2. Contact area physicians to obtain information to complete investigations and reports. 3. Outreach to physicians and other medical providers to inform about and encourage reporting of notifiable diseases. **4.** Participate with DSHS in an MRSA reporting pilot	97: Communicable Diseases, Subchapter A: Control of Communicable Diseases, Rule§97.6: Reporting and Other Duties of Local Health Authorities and Regional Directors.	2. Report from the MRSA pilot 3. Report to local ICPS regarding communicable disease in the community.

Texas Department of State Health Services
FY 2011 Local Public Health Services Funds
Project Service Delivery Plan
Quarterly and Final Performance Report

Local Health Department:	**Contact:**	**Contact Phone:**
Address: ***Include City, State, Zip***		
Contact Email:	**Authorized Signature:**	**Date:**

Quarterly reports must be completed and submitted by the dates shown below. Complete the report table by providing the status of contract activities, identifying barriers to completing the activities, and listing deliverables. This report form should be completed cumulatively (each quarter's report added on to the previous report) and submitted to the Local Public Health Services Team, Division for Regional and Local Health Services at: LocalPHTeam@dshs.state.tx.us. The signature page should be faxed to the attention of the Local Team at: **512-458-7154.** For technical assistance or questions contact the Local Team at 512-458-7770, or email at LocalPHTeam@dshs.state.tx.us. Please note that the **4th Quarter Report** must also include the **Final Report** with information to document results from the evaluation of services and a plan for improving the services.

This report is designed to "tab" through the items to complete all of the sections. Indicate the reporting Quarter by clicking on the appropriate gray box.

	Reporting Periods	Report Due Date
☐ 1st Quarter	September 1st thru November 30th	December 31st
☐ 2nd Quarter	December 1st thru February 28th	March 31st
☐ 3rd Quarter	March 1st thru May 31st	June 30th
☐ 4th Quarter/Final Report	June 1st thru August 31st (Qtr)/September 1st thru August 31st (Final)	September 30th

Public Health Issue(s): ***Briefly describe the public health issue to be addressed. Number issues if more than one issue is addressed.***

Objective(s): ***List the measurable objective(s) to be achieved by using resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc)***

Local Health Department:

	Activity – *list each activity conducted to meet the objective. Use numbering system to designate match with objectives and issues.*	**Status of Activity** ***Provide status of each activity for the reporting quarter***	**Barriers to conducting activities:** ***List any problems or barriers encountered that impact your ability to conduct or complete the activity***	**Deliverables:** ***List the deliverable that provides tangible evidence that the activity was completed (4th quarter only)***
Q1				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Beginning with the Q2 report, incorporate improvement activities listed in the Project Service Delivery Plan. Please specify if these improvement activities will replace or amend any of the activities listed in the Q1 Report.				
Q2				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Q3				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Q4				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			

Texas Department of State Health Services
FY 2011 Local Public Health Services Funds
Project Service Delivery Plan
Quarterly and Final Performance Report

FINAL REPORT		
Local Health Department:		
The information requested below should be completed and submitted* ONLY *with the 4th Quarter's report after the project period is completed. Duplicate the table below as needed for each objective listed in the FY 2008 Service Delivery Plan.		
Objective: ***List each objective outlined in the Service Delivery Plan.***	**Status:** ***Document whether or not the objective was achieved***	**Comments:** *Provide an explanation if objective was not met*

Evaluation Results and Improvement Plan: *Describe the findings from the evaluation of project. List activities that will be conducted during the next contract term to improve the essential public health services or meet the objective. Also, include a plan for improving or amending activities for objectives that were not met during this contract term.*

Evaluation Standard:

Evaluation Activities:

Results/Findings:

Improvement Plan:

NOTICE

Refer to 2nd Excel file via email for DSHS Categorical Budget Forms

TEXAS Department of State Health Services

Division for Regional and Local Health Services

FY 2011 Local Public Health Services

FORM A - FACE PAGE

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*The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.

5) TYPE OF ENTITY (check all that apply):

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- ☒ Regions/Counties/LHD
- ☐ Other Political Subdivision
- ☐ State Agency
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- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith-based Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

*If incorporated, provide 10-digit charter number assigned by Secretary of State:

6) COUNTIES OR REGION SERVED BY PROJECT: Fort Bend County
See attached County/Region list.

7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: Nancy Drake R.N. Phone: 281-238-3548 Fax: 281-342-7371 E-mail: Nancy.drake@co.fort-bend.tx.us	☐ LPHS $ 34,681.00

The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications attached in FORM E, and will provide services in accordance with 25 Texas Administrative Code, §§37.51-37.65. This document has been duly authorized by the governing body of the applicant and I (the person signing below) am authorized to represent the applicant.

8) AUTHORIZED REPRESENTATIVE	9) SIGNATURE OF AUTHORIZED REPRESENTATIVE
Name: Robert E. Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-8609 E-mail: werleann@co.fort-bend.tx.us	10) DATE June 15, 2010

*Form A – FACE PAGE must be faxed with signature to (512) 458 7154

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category
Detail Form

Legal Name of Respondent: **Fort Bend County Clinical Health Services**

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
Optiplex 780 Minitower Base Standard PSU with 19 inch monitor	For communication with NEDSS system server and for case research and data entry	1	$1,101	$1,101
				$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: **$1,101**

Revised: 7/6/2009