TEXAS Department of State Health Services

FY 2016/17 Local Public Health Services

FORM A - FACE PAGE

RESPONDENT INFORMATION

1) LEGAL NAME: Fort Bend County

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

Fort Bend County
Clinical Health Services
4520 Reading Road, Suite A-200
Rosenberg, Texas 77471

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

Fort Bend County Auditor
301 Jackson Street
Richmond, Texas 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
- X 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:

See attached County/Region list.

7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: Kaye Reynolds Phone: 281-238-3519 Fax: 281-342-3355 E-mail: Kaye.Reynolds@fortbendcountytx.gov	• **LPHS** $ 56,182.00

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	
Name: Robert Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-8609 E-mail: Ann.Werelein@fortbendcountytx.gov	**9) DATE 10:** 5/14/2015 **Authorized Signature**

FY 2016/17 Local Public Health Services

Division for Regional and Local Health Services
Program Contact Information
Contract Term: September 1, 2015 through August 31, 2017

Legal Name of Applicant: Fort Bend County

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 the Regional and Local Health Service & Compliance Branch, Mail Code 1990, P.O. Box 149347, Austin, TX 78714 or email to ***LocalPHTeam@dshs.state.tx.us*** *.*

Director

		Mailing Address (street, city, county, state, & zip):
Contact:	Kaye Reynolds, MPH	
Title:	Deputy Director	4520 Reading Road, Suite A-100
Phone:	281-238-3519	Rosenberg, Texas 77471
Fax:	281-238-3355	
E-mail:	Kaye.Reynolds@fortbendcountytx.gov	

Financial Manager

		Mailing Address (street, city, county, state, & zip):
Contact:	Ed Sturdivant	
Title:	County Auditor	701 Jackson Street
Phone:	281-341-3760	Richmond, Texas 77469
Fax:	281-341-3774	
E-mail:	Robert.Sturdivant@fortbendcountytx.gov	

Contract Coordinator

		Mailing Address (street, city, county, state, & zip):
Contact:	Catalina Lozano	
Title:	Epidemiologist	4520 Reading Road, Suite A-200
Phone:	281-238-3579	Rosenberg, Texas 77471
Fax:	281-344-6104	
E-mail:	Catalina.Lozano@fortbendcountytx.gov	

Additional Staff

		Mailing Address (street, city, county, state, & zip):
Contact:	Diane Guest	
Title:	Administrative Assistant	4520 Reading Road, Suite A-200
Phone:	281-238-3558	Rosenberg, Texas 77471
Fax:	281-342-7371	
E-mail:	Diane.Guest@fortbendcountytx.gov	

Additional Staff

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

EXHIBIT A

FY 2016/17 Request for Local Public Health Services Funds
Project Service Delivery Plan

Texas Department of State Health Services

Local Health Department: Fort Bend County

Contract Term: September 1, 2015 through August 31, 2017

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.***
The continuing growth of Fort Bend County brings the ever increasing number of medical facilities and practitioner. 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 in 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 and 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 Service 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*	**Evaluation and Improvement Plan** *List the standard and describe how it is used to evaluate the activities conducted.*	**Deliverable** *Describe the tangible evidence that the activity was*

designate match between issues/programs and objectives.	*This can be a local, state or federal guideline.*	*completed.*
1. Enter all reported cases into the NEDSS system for reporting to the Texas Department of State Health Services. 2. Contract area physicians to obtain information to complete investigations and reports. 3. Outreach to physicians and other medical providers to inform about and encourage reporting and notifiable diseases. 4. Participate with DSHS in any special surveillance/reporting initiatives.	**Activities under this program will be guided by the Texas Administrative Code, Title 25: Health Service, Part 1: Department of State Health Services, Chapter 97: Communicable Diseases Subchapter A: Control of Communicable Diseases. Rule 97.6: Reporting and other Duties of Local Health Authorities and Regional Directors.**	1. Database of notifiable conditions in the NEDSS system. 2. Report from special surveillance/reporting initiatives. 3. Report to local ICP's and school nurses regarding communicable disease in the community

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: Fort Bend County Clinical Health Services

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	$31,700	$31,700	$0	$0	$0	$0
B. Fringe Benefits	$18,928	$18,928	$0	$0	$0	$0
C. Travel	$2,465	$2,465	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$3,089	$3,089	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$0	$0	$0	$0	$0	$0
H. Total Direct Costs	$56,182	$56,182	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$56,182	$56,182	$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 Catetory	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	**Personnel**	**$31,700**	**$31,700**	**Fringe Benefits**	**$18,928**	**$18,928**
	Travel	**$2,465**	**$2,465**	**Equipment**	**$0**	**$0**
	Supplies	**$3,089**	**$3,089**	**Contractual**	**$0**	**$0**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$56,182**	**Budget Total**	**$56,182**

*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: Fort Bend County Clinical Health Services

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
Clerk III	N	For entry of otifiable conditions into the state NEDSS system - contact with providers for accurate and complete information (20 hours per week)	0.5	N/A	$2,641.63	24	$31,700
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$31,700

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

FICA 7.65%, Pension 11.79%, W/C 3.8%, Health Insurance $11,561 per FTE

Fringe Benefit Rate %	59.71%
Fringe Benefits Total	$18,928

Revised: 7/6/2009

Total for Conference / Workshop Travel $740

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Local travel to visit PMD's within the county regarding reporting requirements	3000	$0.575	$1,725		$1,725
			$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 $1,725

Other / Local Travel Costs: $1,725 **Conference / Workshop Travel Costs:** $740 **Total Travel Costs:** **$2,465**

Indicate Policy Used: **Respondent's Travel Policy** X **State of Texas Travel Policy**

Revised: 7/6/2009

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: Fort Bend County Clinical Health Services

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
NEDSS Training or other reporting / surveillance training sponsored by DSHS - Year 1	Increaed knowledge and efficiency in use of the NEDSS base system reporting and analysis components	Austin	2 days / 1 employee	Mileage	$173
				Airfare	$0
				Meals	$72
				Lodging	$125
				Other Costs	
				Total	$370
NEDSS Training or other reporting / surveillance training sponsored by DSHS - Year 2	Increaed knowledge and efficiency in use of the NEDSS base system reporting and analysis components	Austin	2 days / 1 employee	Mileage	$173
				Airfare	$0
				Meals	$72
				Lodging	$125
				Other Costs	
				Total	$370
				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

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent: Fort Bend County Clinical Health Services

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 [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
General Office Supplies	paper, pens and other supplies to maintain the efforts of the position	$689
Reporting materials for physicians	Presentation of reporting and surveillance information to physicians and other medical providers in the community to encourage timely and accurate reporting of all reportable conditions	$2,400
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$3,089**

Revised: 7/6/2009