TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

JOHN HELLERSTEDT, M.D.
COMMISSIONER

April, 22, 2016

Fort Bend County Health & Human Services Department

RE: Contract for Fiscal Year 2017

Dear Ms. Reynolds,

The Texas Department of State Health Services, Tuberculosis (TB) Services Branch, is initiating the contract process for fiscal year (FY) 2017. The Inter-Local Application will be distributed at a later date.

The contract period for the FY17 TB/State Contract is 9/01/15-8/31/17 because we are now considering this term to be an amendment to extend through August 31, 2017.

The allocation for 9/01/16-8/31/17 is $134,397.00. Contractor shall provide a match of no less than 20% of the DSHS share of the budget which is $26,879.00. The due date for submission of the Budget to DSHS is May 11, 2016. Please submit via email to Kathy Sharp at the email address noted below. The contract expenditures will be closely scrutinized and expenses not considered absolutely essential for delivery of direct client services may be eliminated or reduced.

In the event that the Texas Department of State Health Services (DSHS) is informed of state increases or decreases to funding amounts, or other unforeseen internal budgetary shortfalls, DSHS may find it necessary to amend funding allocations to its contractors.

If you have any questions or need additional information, please contact Kathy Sharp, Contract Manager, Disease Control and Prevention Services, Contract Management Unit at (512) 776-2640 or by e-mail at kathy.sharp@dshs.state.tx.us

Sincerely,

Kathy Sharp, Contract Manager
Division for Disease Control and Prevention Services
Contract Management Unit

Attachment

cc: Sandra A. Morris, M.P.H., Manager, Tuberculosis and Refugee Health Services Branch
Peggy Wittie, PhD, MAG, Manager, Tuberculosis and Hansen's Disease Group
Cynthia Lewis, Program Specialist, Tuberculosis and Refugee Health Services Branch
Pamela Mineba, Unit Resource Lead, Tuberculosis and Refugee Health Services Branch

Department of State Health Services
Form A Face Page – Tuberculosis (TB) Funding

RESPONDENT INFORMATION

1) **LEGAL BUSINESS NAME:** Fort Bend County Clinical Health Services

2) **MAILING Address Information** (include mailing address, street, city, county, state and 9-digit zip code): **Check if address change** ☐

4520 Reading Road, Suite A-200 Rosenberg, Texas 77471

3) **PAYEE Name and Mailing Address, including 9-digit zip code** (if different from above): **Check if address change** ☐

Fort Bend County Auditor-301 Jackson Street, Suite 701-Richmond Texas 77469

4) **DUNS Number (9-digit) required if receiving federal funds:**

5) **Federal Tax ID No.** (9-digit), **State of Texas Comptroller Vendor ID Number** (14-digit) or **Social Security Number** (9-digit): 746001969

The respondent acknowledges, understands and agrees that the respondent'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.

6) **TYPE OF ENTITY** (check all that apply):

- ☐ City
- x County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith Based (Nonprofit Org)
- ☐ Individual
- ☐ Federally Qualified Health Centers
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

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

7) **PROPOSED BUDGET PERIOD:** **Start Date:** 09/01/2016 **End Date:** 08/31/2017

8) **COUNTIES SERVED BY PROJECT:**
Fort Bend County

9) **AMOUNT OF FUNDING REQUESTED:**

10) **PROJECTED EXPENDITURES**

Does respondent's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for respondent's current fiscal year (excluding amount requested in line 9 above)? **

Yes ☐ No ☐

***Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.*

11) **PROJECT CONTACT PERSON**

Name: Kaye Reynolds, DrPH
Phone: 281-238-3519
Fax: 281-342-7371
Email: Kaye.Reynolds@fortbendcountytx.gov

12) **FINANCIAL OFFICER**

Name: Ed Sturdivant
Phone: 281-341-3760
Fax: 281-341-3374
Email: Ed.Sturdivant@fortbendcountytx.gov

The facts affirmed by me in this proposal are truthful and I warrant the respondent is in compliance with the assurances and certifications contained in **APPENDIX B: DSHS Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the respondent and I (the person signing below) am authorized to represent the respondent.

13) **AUTHORIZED REPRESENTATIVE** **Check if change** ☐

Signature:

Name: Robert Hebert
Title: County Judge
Phone: 281-341-8608
Fax: 281-341-6809
Email: 281-341-6809

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: Fort Bend County

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding (Match) (5)	Other Funds (6)
A. Personnel	$106,398	$79,518			$26,880	
B. Fringe Benefits	$36,014	$36,014			$0	
C. Travel	$3,754	$3,754			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$400	$400			$0	
F. Contractual	$14,711	$14,711			$0	
G. Other	$0	$0			$0	
H. Total Direct Costs	$161,277	$134,397	$0	$0	$26,880	$0
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$161,277	$134,397	$0	$0	$26,880	$0
K. Program Income - Projected Earnings	$0	$0	$0	$0	$0	$0

NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts in whole dollars for (3), (4), & (6), *if applicable*. 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**	**$106,398**	**$106,398**	**Fringe Benefits**	**$36,014**	**$36,014**
	Travel	**$3,754**	**$3,754**	**Equipment**	**$0**	**$0**
	Supplies	**$400**	**$400**	**Contractual**	**$14,711**	**$14,711**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	Distribution Totals	$161,277	Budget Total	$161,277

*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

PERSONNEL Name + Functional Title 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
TB Program Manager	N	Manges TB Program	1	RN	$5,078.00	12	$60,936
DOT/ Contact Investigator	N	Dot/Contact Investigation	0.5	LVN	$3,097.00	12	$18,582
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$79,518

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 %	45.29%
	Fringe Benefits Total	$36,014

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: Fort Bend County

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
TB Symposium	Discuss and review TB surveillance in the state of Texas	Austin, Tx		Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
TB Contractor Meeting	Review TB Program Contracts and ways to improve the program.	Austin, Tx		Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $0

Revised: 1/27/2012

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
DOT/ Contact Investigation	6952	$0.540	$3,754		$3,754
			$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 $3,754

Other / Local Travel Costs: $3,754 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** **$3,754**

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

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent: Fort Bend County

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**
Personal Protective Equipment	N-95 masks, Latex gloves for staff, procedure mask for pt	$200
Supplies for administration of tests, blood draws and sputum collection	Nebulizer kits, contton balls, 2x2 gauze, band-aids, towels for counter, tourniquets-for testing and specimen collection	$200
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$400**

Revised: 1/27/2012

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent:

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding (Match) (5)	Other Funds (6)
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NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts in whole dollars for (3), (4), & (6), *if applicable*. 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**	**$106,398**	**$106,398**	**Fringe Benefits**	**$36,014**	**$36,014**
	Travel	**$3,754**	**$3,754**	**Equipment**	**$0**	**$0**
	Supplies	**$400**	**$400**	**Contractual**	**$14,711**	**$14,711**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$161,277**	**Budget Total**	**$161,277**

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