

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 II	NFORMATION
1) LEGAL BUSINESS NAME: Fort Bend County Clini	ical Health Services
 MAILING Address Information (include mailing address, street, city, count 4520 Reading Road, Suite A-200 Rosenber 	ty, state and 9-digit zip code): Check if address change
PAYEE Name and Mailing Address, including 9-digit zip code (if different and Bend County Auditor-301 Jackson Street)	
4) DUNS Number (9-digit) required if receiving federal funds:	
5) Federal Tax ID No. (9-digit), State of Texas Comptroller Vendor ID Num Security Number (9-digit):	
*The respondent acknowledges, understands and agrees that the respondent's choice to us result in the social security number being made public via state open records requests.	se a social security number as the vendor identification number for the contract, ma
6) TYPE OF ENTITY (check all that apply): City X County Other Political Subdivision State Agency Indian Tribe Minority Organization Faith Based (Nonpro	Federally Qualified Health Centers State Controlled Institution of Higher Learning Organization Hospital Private Offit Org) Other (specify):
7) DECEMENT DUDGET DEDICE	9/01/2016 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. The facts affirmed by me in this proposal are truthful and I warrant the respondent is in a post of the facts affirmed by the facts affirmed	Fax: 281-342-7371 Kaye.Reynolds@fortbendcountyt x.gov 12) FINANCIAL OFFICER Name: Ed Sturdivant Phone: 281-341-3760 Fax: 281-341-3374 Ed.Sturdivant@fortbendcountytx.gov compliance with the assurances and certifications contained in APPENDIX B:
prepresent the respondent.	erning body of the respondent and I (the person signing below) am authorized
3) AUTHORIZED REPRESENTATIVE Check if change	е
ignature:	
me: Robert Hebert	

Title:

Phone: Fax:

Email:

County Judge 281-341-8608

281-341-6809

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: Fort Bend County

The state of the s		and the state of t		The state of the s	The state of the s		
\$0	\$0	\$0	\$0	\$0	\$0	Program Income - Projected Earnings	7
\$0	\$26,880	\$0	\$0	\$134,397	\$161,277	Total (Sum of H and I)	زـ
	\$0			\$0	\$0	Indirect Costs	_
\$0	\$26,880	\$0	\$0	\$134,397	\$161,277	Total Direct Costs	工
	\$0			\$0	\$0	Other	<u>G</u>
	\$0			\$14,711	\$14,711	Contractual	Ή.
	\$0			\$400	\$400	Supplies	im
	\$0			\$0	\$0	Equipment	D
	\$0			\$3,754	\$3,754	Travel	C.
	\$0			\$36,014	\$36,014	Fringe Benefits	œ
	\$26,880			\$79,518	\$106,398	Personnel	Þ.
(6)	(5)	(4)	(3)	(2)	(1)		
Funds	(Match)	Agency Funds*	Funds	Requested	Budget	Budget Categories	œ
Other	Local Funding	Other State	Direct Federal	DSHS Funds	Total		
							The second second

"Distribution Total" below equals the respective amount under the "Total Budget" from column (1) NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts Check Totals For: in whole dollars for (3), (4), & (6), if applicable. After amounts have been entered for each funding source, verify that the Catetory Budget Personnel Supplies Travel Other Distribution Total \$106,398 \$3,754 \$400 \$0 Budget Total \$106,398 Fringe Benefits \$3,754 Equipment \$400 Contractual \$0 Indirect Costs Category Budget Distribution Total \$14,711 \$36,014 \$0 \$0 Budget Total \$36,014 \$14,711

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

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. respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution *Letter(s) of good standing that validate the respondent's programmatic, administrative, and financial capability must be placed after this form if

FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent: Fort Bend County

PERSONNEL Vacant Name + Functional Title b = Existing or P = Proposed Vacant VIN Justification FTE's Name + Functional Title License (Enter NA if Not required) Certification or License (Enter NA if Not required) Total Average Monthly Not Requested for Project Number Project Requested for Project 20 TOTAL Investigation 0.5 LVN \$3,097.00 12 \$60,936 \$0.936 30 Solary/Wage 50 Jeven 50 Jeven 50 Jeven 50 Jeven 50 Jeven 30 Solary/Wage 50 Jeven 50 Jeven 50 Jeven 50 Jeven 50 Jeven 30 Solary/Wage 50 Jeven 50 Jeven 50 Jeven 50 Jeven 50 Jeven 30 Solary/Wage 50 Jeven 50 Jeven 50 Jeven 50 Jeven 50 Jeven 30 Solary/Wage 50 Jeven 50 Jeven 50 Jeven 50 Jeven 50 Jeven 30 Solary/Wage 50 Jeven 50 Jeven 50 Jeven 50 Jeven 50 Jeven 30 Solary/Wage 50 Jeven 50 Jeven 50 Jeven 50 Jeven 50 Jeven 30 Jeven 50 Jeven 50 Jeven 50 Jeven 50				ow:	pace belo	Itemize the elements of fringe benefits in the space below:	FRINGE BENEFITS Itemize
NNNEL Vacant citonal Title Vacant citonal Title Vacant citonal Title Vacant citonal Title Certification or lite citonse (Enter NA if Proposed Total Average Number Request Request Request Number Request Request Number Number Request Number Number Request Number	\$79,518	Total	SalaryWage				
WNREL Vacant citional Title Vacant victional Title Vacant victional Title Vacant viction of Proposed Certification or License (Enter NA if N/IN) Total Average Number Request Request Request Project Request Project Request Project Request	\$0	BET SHEETS	PLEMENTAL BUDG	OM PERSONNEL SUP	TOTAL FR		
NUNEL Vacant citional Title Vacant V/IN Vacant Justification Certification or License (Enter NA if Proposed Certification or License (Enter NA if Proposed Total Average Number Requestion Salary/Number Requestion N Manges TB Program 1 RN \$5,078.00 12 pator N Dot/Contact Investigation 0.5 L/VN \$3,097.00 12 pator N Salary/Number Requestion Salary/Number Requestion Salary/Number Requestion Project pator N Dot/Contact Investigation 0.5 L/VN \$3,097.00 12 pator N Salary/Number Requestion Salary/Number Requestion Number Requestion Project pator N Dot/Contact Investigation 0.5 L/VN \$3,097.00 12	\$0						
Vacant citional Title Vacant Y/N Justification FTE's Certification or License (Enter NA if Projection) Total Average Number Requestion Salary/N Number Requestion N Manges TB Program 1 RN \$5,078.00 12 pator N Dot/Contact Investigation 0.5 LVN \$3,097.00 12	\$0						
Vacant citional Title Vacant Vacant Proposed Vacant VIN Justification FTE's Proposed Certification or License (Enter NA if Salary/Mage Monthly Number Number Requestion Number Requestion Requestion 1 RN \$5,078.00 12 Project pator N Dot/Contact Investigation 0.5 LVN \$3,097.00 12	\$0						
Value Lectional Title Vacant Vacant Vacant Vacant Certification or Vacant Total Average License (Enter NA if VIN) SalaryNage Proposed Certification or Monthly License (Enter NA if VIN) Monthly Salary/Wage Number Request Project Request Project Jator N Dot/Contact Investigation 0.5 LVN \$3,097.00 12 Jator N Dot/Contact Investigation 0.5 LVN \$3,097.00 12	\$0						
VNNEL Vacant citional Title Vacant required Vacant vacant value Certification or License (Enter NA if value) Total Average Number Requestion Salary/Number Requestion Number Requestion Requestion Number Requestion Number Requestion Number Requestion Project pator Number Dot/Contact Investigation 0.5 LVN \$3,097.00 12 pator Number Requestion Number Requestion 1 Number Requestion Project pator Number Requestion 0.5 LVN \$3,097.00 12 pator Number Requestion Number Requestion Number Requestion Number Requestion Number Requestion project Number Requestion Number Requestion Number Requestion Number Requestion Number Requestion project Number Requestion Number Requestion Number Requestion Number Requestion Number Requestion project Number Requestion Number Requestion Number Requestion Number Requestion Number Requestion project Number Requestion Number Requestion Number Requestion Number Requestion Number Requestion project </td <td>\$0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	\$0						
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VNNEL Vacant P = Proposed Vacant P = Proposed Vacant Y/N Justification Justification FTE's PTE's Certification or License (Enter NA if Proposed PTE) Total Average Monthly Number Request Request PTE Proposed Number Request PTE Proposed Number Request PTE Proposed Number PTE's PTO	\$0						
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NNEL Certification or Composed Total Average Monthly Salary/N Number Salary/N Request V=Proposed Y/N Justification FTE's not required) License (Enter NA if Salary/Wage of Months Project Of Months Project N Manges TB Program 1 RN \$5,078.00 12	\$18,582	12	\$3,097.00	LVN	0.5	Dot/Contact Investigation	DOT/ Contact Investigator N
Vacant Value Total Average License (Enter NA if Monthly Number Salary/Wage of Months)	\$60,936	12	\$5,078.00	RN		Manges TB Program	TB Program Manager N
	Salary/Wages Requested for Project	Number of Months		Certification or License (Enter NA if not required)	FTE's	Justification	

				FICA 7.65%, Pension 11.79%, W/C 3.8%, Health Insurance \$11,561 per FTE	FRINGE BENEFITS Itemize the elements of fringe benefits in the space below:
Fringe Benefits Total		Fringe Benefit Rate %			7.
\$36,014		45.29%	Andrew An		

FORM 1-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Fort Bend County

\$0		BUDGET SHEETS		TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP	
\$0	Total				
\$0	Other Costs				
\$0	Lodging				
\$0	Meals				
\$0	Airfare				
\$0	Mileage				
\$0	Total				
\$0	Other Costs				
\$0	Lodging				
\$0	Meals				
\$0	Airfare				
\$0	Mileage				
\$0	Total				
\$0	Other Costs				
\$0	Lodging		Adomi, IX	program.	G
\$0	Meals		Δuetin Ty	Review TB Program Contracts and ways to improve the	TB Contractor Meeting
\$0	Airfare				
\$0	Mileage				
\$0	Total				
\$0	Other Costs				
\$0	Lodging		Augui, ix	Closed and Louis M. L. adi solliding ill the attice of Leyda	
\$0	Meals		Δuctin Tv	Discuss and review TR surveillance in the state of Toyas	TB Symposium
\$0	Airfare				
\$0	Mileage				
	I lavei Costs	Days/Employees	City/State	Justilication	Collicianical Moleving
	Tanad Cart	Number of:	Location	lindiff nation	Description of
					Contratence / Morwallob Haver Costs

Total for Conference / Workshop Travel

\$0

State of Texas Travel Policy	State of Texa		Respondent's Travel Policy		Indicate Policy Used:
el Costs: \$3,754	Total Travel Costs:	\$0	Conference / Workshop Travel Costs:	Co	Other / Local Travel Costs: \$3,754
Travel \$3,754	Total for Other / Local Travel	Total f			
\$0	SUDGET SHEETS	AVEL COSTS E	TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS	OM TRAVEL	TOTAL FR
\$0		\$0			
\$0		\$0			
\$0		\$0			
\$0		\$0			
\$0		\$0			
\$0		\$0	40		
\$3,754		\$3,754	\$0.540	6952	DOT/ Contact Investigation
Total (a) + (b)	Other Costs (b)	Mileage Cost (a)	Mileage Reimbursement Rate	Number of Miles	Justification
					Other / Local Travel Costs

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent:	

\$0	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	
\$200	Supplies for administration of tests, blood draws and Nebulizer kits, contton balls, 2x2 gauze, band-aids, towels for sputum collection counter, tourniquets-for testing and specimen collection	Supplies for administration of tests, blood draws and sputum collection
\$200	N-95 masks, Latex gloves for staff, procedure mask for pt	Personal Protective Equipment
Total Cost	Purpose & Justification	Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]
supply item. Costs may complete this form.	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.	Itemize and describe each supply item and provide an estimated qua be categorized by each general type (e.g., office, computer, medical, ec

Total Amount Requested for Supplies:

FORM I: BUDGET SUMMARY (REQUIRED)

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

\$0	\$0	\$0 Indirect Costs	\$0	\$0	Other	
\$14,711	\$14,711	\$400 Contractual		\$400	Supplies	
\$0	\$0	\$3,754 Equipment	\$3,754	\$3,754	Travel	
\$36,014	\$36,014	\$106,398 Fringe Benefits	\$106,398	\$106,398	Personnel	Check Totals For:
Total	Total	Category	Total	Total	Catetory	
Budget	Distribution	Budget	Budget	Distribution	Budget	
). 	et" from column (1	er the "Total Budg	ective amount und	w equals the response	"Distribution Total" below equals the respective amount under the "Total Budget" from column (1)
t the	source, verify that	ed for each funding	s have been entere	ble. After amount	(4), & (6), if applica	in whole dollars for (3), (4), & (6), if applicable. After amounts have been entered for each funding source, verify that the
Enter amounts	e funding sources.	pulated among th	y will have to be po	h Budget Category	jet" amount for eac	NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts

sources in column 3 that is not related to activities being funded by this DSHS project. of higher education, letter(s) of good standing are not required. DO NOT include funding from other state agencies in column 4 or Federal respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution *Letter(s) of good standing that validate the respondent's programmatic, administrative, and financial capability must be placed after this form if

TOTAL FOR:

Distribution Totals

\$161,277 Budget Total

\$161,277