


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

<b>RESPONDENT INFORMATION</b>	
<b>1) LEGAL BUSINESS NAME:</b>	Fort Bend County
<b>2) MAILING Address Information</b> (include mailing address, street, city, county, state and 9-digit zip code):	4520 Reading Road, Suite A-200 Rosenberg, Texas 77471 <span style="float: right;">Check if address change <input type="checkbox"/></span>
<b>3) PAYEE Name and Mailing Address, including 9-digit zip code</b> (if different from above):	Fort Bend County Auditor-301 Jackson Street, Suite 701- Richmond, Texas 77469 <span style="float: right;">Check if address change <input type="checkbox"/></span>
<b>4) DUNS Number</b> (9-digit) required if receiving federal funds:	
<b>5) Federal Tax ID No.</b> (9-digit), <b>State of Texas Comptroller Vendor ID Number</b> (14-digit) or <b>Social Security Number</b> (9-digit):	746001969
<small>*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.</small>	
<b>6) TYPE OF ENTITY</b> (check all that apply):	
<input type="checkbox"/> City <input checked="" type="checkbox"/> County <input type="checkbox"/> Other Political Subdivision <input type="checkbox"/> State Agency <input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Nonprofit Organization* <input type="checkbox"/> For Profit Organization* <input type="checkbox"/> HUB Certified <input type="checkbox"/> Community-Based Organization <input type="checkbox"/> Minority Organization <input type="checkbox"/> Faith Based (Nonprofit Org)
<input type="checkbox"/> Individual <input type="checkbox"/> Federally Qualified Health Centers <input type="checkbox"/> State Controlled Institution of Higher Learning <input type="checkbox"/> Hospital <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): _____	
<small>*If incorporated, provide 10-digit charter number assigned by Secretary of State:</small>	
<b>7) PROPOSED BUDGET PERIOD:</b>	Start Date: 09/01/2017      End Date: 08/31/2018
<b>8) COUNTIES SERVED BY PROJECT:</b> Fort Bend County	
<b>9) AMOUNT OF FUNDING REQUESTED:</b> # 134,397.00	<b>11) PROJECT CONTACT PERSON</b>
<b>10) PROJECTED EXPENDITURES</b> 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 <input type="checkbox"/> No <input type="checkbox"/>  <small>**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.</small>	Name: Kaye Reynolds, Dr PH Phone: 281-238-3519 Fax: 281-342-7371 Email: Kaye.Reynolds@fortbendcountytexas.gov
<b>12) FINANCIAL OFFICER</b>	
Name: Ed Sturdivant Phone: 281-341-3760 Fax: 281-341-3374 Email: Ed.Sturdivant@fortbendcountytexas.gov	
<small>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 <b>APPENDIX B: DSHS Assurances and Certifications</b>. 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.</small>	
<b>13) AUTHORIZED REPRESENTATIVE</b> <span style="float: right;">Check if change <input type="checkbox"/></span>	
Name: Robert Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-6809 Email: Robert.Hebert@fortbendcountytexas.gov	 1-10-2017

Legal Name of Respondent:

Fort Bend County

**FORM I-2: TRAVEL Budget Category Detail Form**

Conference / Workshop Travel Costs		Justification	Location City/State	Number of:		Travel Costs	
Description of Conference/Workshop	Days/Employees			Days/Employees			
NEDDS Training or other reporting/surveillance training sponsored by DSHS - Year 1	Increased knowledge and efficiency in use of the NEDDS base system reporting and analysis components	Austin	2 days / 1 employee	Mileage	\$175	Airfare	\$0
				Meals	\$72	Lodging	\$158
				Other Costs		Total	\$405
NEDDS Training or other reporting/surveillance training sponsored by DSHS - Year 2	Increased knowledge and efficiency in use of the NEDDS base system reporting and analysis components	Austin	2 days / 1 employee	Mileage	\$175	Airfare	\$0
				Meals	\$72	Lodging	\$158
				Other Costs		Total	\$405
				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

Total for Conference / Workshop Travel

Revised 8/16/2009

# 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	\$116,425	\$88,056			\$28,369	
B. Fringe Benefits	\$43,726	\$43,726			\$0	
C. Travel	\$1,015	\$1,015			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$0	\$0			\$0	
F. Contractual	\$1,600	\$1,600			\$0	
G. Other	\$0	\$0			\$0	
H. Total Direct Costs	\$162,766	\$134,397		\$0	\$28,369	\$0
I. Indirect Costs	\$0	\$0			\$0	
J. Total (Sum of H and I)	\$162,766	\$134,397		\$0	\$28,369	\$0
K. Program Income - Projected Earnings	\$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), & (5), 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).**

Check Totals For:	Budget Category	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
	Personnel	\$116,425	\$116,425	Fringe Benefits	\$43,726	\$43,726
	Travel	\$1,015	\$1,015	Equipment	\$0	\$0
	Supplies	\$0	\$0	Contractual	\$1,600	\$1,600
	Other	\$0	\$0	Indirect Costs	\$0	\$0
<b>TOTAL FOR:</b>	<b>Distribution Totals</b>	<b>\$162,766</b>	<b>\$162,766</b>	<b>Budget Total</b>	<b>\$162,766</b>	<b>\$162,766</b>

\* 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.



**Other / Local Travel Costs**

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
DOT/Contact Investigation	1880	\$0.540	\$1,015		\$1,015
			\$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





