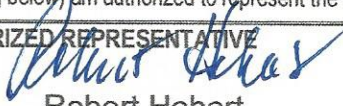


**Department of State Health Services
Form A Face Page – Tuberculosis (TB) Funding**

RESPONDENT INFORMATION																			
1) LEGAL BUSINESS NAME: Fort Bend County																			
2) MAILING Address Information (include mailing address, street, city, county, state and 9-digit zip code): Check if address change <input type="checkbox"/> Fort Bend County – 301 Jackson Street, Richmond, Texas 77469																			
3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above): Check if address change <input type="checkbox"/> 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																			
<i>*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.</i>																			
6) TYPE OF ENTITY (check all that apply):																			
<table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> City</td> <td><input type="checkbox"/> Nonprofit Organization*</td> <td><input type="checkbox"/> Individual</td> </tr> <tr> <td><input checked="" type="checkbox"/> County</td> <td><input type="checkbox"/> For Profit Organization*</td> <td><input type="checkbox"/> Federally Qualified Health Centers</td> </tr> <tr> <td><input type="checkbox"/> Other Political Subdivision</td> <td><input type="checkbox"/> HUB Certified</td> <td><input type="checkbox"/> State Controlled Institution of Higher Learning</td> </tr> <tr> <td><input type="checkbox"/> State Agency</td> <td><input type="checkbox"/> Community-Based Organization</td> <td><input type="checkbox"/> Hospital</td> </tr> <tr> <td><input type="checkbox"/> Indian Tribe</td> <td><input type="checkbox"/> Minority Organization</td> <td><input type="checkbox"/> Private</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Faith Based (Nonprofit Org)</td> <td><input type="checkbox"/> Other (specify): _____</td> </tr> </table>		<input type="checkbox"/> City	<input type="checkbox"/> Nonprofit Organization*	<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> County	<input type="checkbox"/> For Profit Organization*	<input type="checkbox"/> Federally Qualified Health Centers	<input type="checkbox"/> Other Political Subdivision	<input type="checkbox"/> HUB Certified	<input type="checkbox"/> State Controlled Institution of Higher Learning	<input type="checkbox"/> State Agency	<input type="checkbox"/> Community-Based Organization	<input type="checkbox"/> Hospital	<input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Minority Organization	<input type="checkbox"/> Private		<input type="checkbox"/> Faith Based (Nonprofit Org)	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> City	<input type="checkbox"/> Nonprofit Organization*	<input type="checkbox"/> Individual																	
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<input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Minority Organization	<input type="checkbox"/> Private																	
	<input type="checkbox"/> Faith Based (Nonprofit Org)	<input type="checkbox"/> Other (specify): _____																	
<i>*If incorporated, provide 10-digit charter number assigned by Secretary of State:</i>																			
7) PROPOSED BUDGET PERIOD: Start Date: 01/01/2018 End Date: 12/31/2018																			
8) COUNTIES SERVED BY PROJECT: Fort Bend County																			
9) AMOUNT OF FUNDING REQUESTED: 99,186.00																			
10) PROJECTED EXPENDITURES Does respondent's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for respondent's <u>current fiscal year</u> (excluding amount requested in line 9 above)? ** Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <i>**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.</i>																			
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 Signature:  Check if change <input type="checkbox"/> 12/15/2017 Name: Robert Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-8609 Email: county.judge@fortbendcountytx.gov																			

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	\$46,080	\$46,080			\$0	
B. Fringe Benefits	\$22,422	\$22,422			\$0	
C. Travel	\$6,003	\$6,003			\$0	
D. Equipment	\$0	\$0			\$0	
E. Supplies	\$0	\$0			\$0	
F. Contractual	\$24,681	\$24,681			\$19,837	
G. Other	\$0	\$0			\$0	
H. Total Direct Costs	\$99,186	\$99,186	\$0	\$0	\$19,837	\$0
I. Indirect Costs	\$0	\$0			\$0	
J. Total (Sum of H and I)	\$99,186	\$99,186	\$0	\$0	\$19,837	\$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 Category	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Personnel	\$46,080	\$46,080	Fringe Benefits	\$22,422	\$22,422
Travel	\$6,003	\$6,003	Equipment	\$0	\$0
Supplies	\$0	\$0	Contractual	\$44,518	\$24,681
Other	\$0	\$0	Indirect Costs	\$0	\$0

TOTAL FOR: Distribution Totals \$119,023 Budget Total \$99,186

*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/DOPT TB suspects, cases, TBil's on 3HP and TBil's at high risk of failure to complete treatment. Contact Investigation of suspects and cases in Ft. Bend Co. Travel to local meetings	11221	\$0.535	\$0		\$6,003
			\$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

Conference / Workshop Travel Costs: Total Travel Costs:

Other / Local Travel Costs: Respondent's Travel Policy:

Indicate Policy Used: State of Texas Travel Policy

35 "To Be Named."

TOTAL
\$6,750
\$2,250
\$406
\$100
\$15,175
\$0
\$0
\$0
\$24,681
\$24,681

Page 2, FORM I - 7 Indirect Costs

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**

FORM I - 7 Indirect Costs

Legal Name of Respondent:

FORT BEND COUNTY

Total amount of indirect costs allocable to the project:

Amount: \$0

Indirect costs are based on (mark the statement that is applicable):

The respondent's most recent indirect cost rate approved by a federal cognizant agency or state single audit coordinating agency. Expired rate agreements are not acceptable. Attach a copy of the rate agreement to this form (Form I - 7 Indirect)

RATE:
BASE:

Applies only to governmental entities. The respondent's current central service cost rate or indirect cost rate based on a rate proposal prepared in accordance with OMB Circular A-87. Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.

RATE:
TYPE:
BASE:

Note: Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date. The CFPM is available on the following internet web link: <http://www.dshs.state.tx.us/contracts/>

GO TO PAGE 2 (below)

SUPPLEMENTAL and MATCH FORMS INSTRUCTIONS

The budget templates include a SUPPLEMENTAL and a MATCH page (one per budget category) that follow are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template. The MATCH pages (one per budget category) are intended to record the required match will be utilized to list detail information for the required match.

The amounts on each supplemental template will automatically populate from the templates and will be inserted on the last line of the primary budget template.

The amounts on each match template will automatically populate from the templates and will be inserted in column labeled "Local Funding Sources (5)"

The SUPPLEMENTAL and MATCH budget templates are:

- Form I-1a Personnel Supplemental
- Form I-2a Travel Supplemental
- Form I-3a Equipment Supplemental
- Form I-4a Supplies Supplemental
- Form I-5a Contractual Supplemental
- Form I-6a Other Supplemental

- Form I-1b Personnel Match
- Form I-2b Travel Match
- Form I-3b Equipment Match
- Form I-4b Supplies Match
- Form I-5b Contractual Match
- Form I-6ba Other Match