

**InterLocal Application  
For  
Immunization Program Funds  
Fiscal Year 2019**

**[www.ImmunizeTexas.com](http://www.ImmunizeTexas.com)**

**Issue date: 12/11/2017**

**Due date: 1/05/2018**

Immunization Unit  
P.O. Box 149347  
Austin, Texas 78714-9347

## I. INTRODUCTION

The Department of State Health Services (DSHS) Immunization Unit announces the expected availability of Fiscal Year (FY) 2019 general revenue and federal funding to prevent and control the transmission of vaccine-preventable diseases in children and adults, with emphasis on accelerating strategic interventions to improve their vaccine coverage levels.

This Inter-Local Application (ILA) contains the requirements that all applicants shall meet to be considered for funding. Each applicant is solely responsible for the preparation and submission of an application in accordance with instructions contained in this ILA.

**Please submit the completed renewal application electronically no later than January 13, 2017 to [DSHSImmunizationContracts@dshs.texas.gov](mailto:DSHSImmunizationContracts@dshs.texas.gov).** If your email is returned for any reason contact Tray Kirkpatrick at 512.776.3448 and/or resubmit your electronic copy to [tray.kirkpatrick@dshs.texas.gov](mailto:tray.kirkpatrick@dshs.texas.gov). Renewal applications received after this deadline will not be considered for funding.

The renewal application includes a form for Indirect Costs (I-7) within the budget template. DSHS Contract Oversight and Support (COS), the section that conducts fiscal audits of contractors, strongly urges that indirect costs be included. Please note that DSHS Immunization Unit has a cap on indirect costs. The total cost that may be funded under this renewal application may not be more than 10% of the personnel costs listed on Form I-1.

## II. APPLICATION POINT OF CONTACT

For purposes of addressing questions concerning this Application, the contact is **Tray Kirkpatrick** of the Contract Management Section. Communications concerning this Application may be addressed by email or fax to:

**Phone and Fax Numbers:**

512.776.3448

512.776.7391 fax

**CMS Contact Email:**

[tray.kirkpatrick@dshs.texas.gov](mailto:tray.kirkpatrick@dshs.texas.gov)

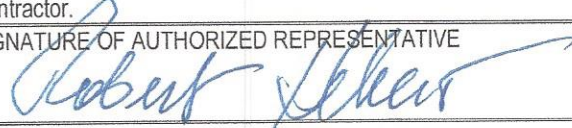
### **III. TABLE OF CONTENTS**

**THE APPLICATION SHOULD INCLUDE A TABLE OF CONTENTS AND BE ORGANIZED AND ARRANGED IN THE FOLLOWING ORDER:**

- Form A. Face Page - Application for Financial Assistance
- Form A-1. Texas Counties and Regions List (see separate file)
- Form B. Table of Contents and Checklist
- Form C. Contact Person Information (last block is for emergency contact)
- Form D. Job Descriptions (if applicable)
- Form E. Program Income Spending Plan
- Form H. Work Plan
- Form I. Budget (see separate file)
- Appendix B. Copy of Approved Indirect Rate (if applicable)



**Department of State Health Services**  
**FORM A: FACE PAGE**

CONTRACTOR INFORMATION	
1) LEGAL BUSINESS NAME: Fort Bend County	
2) MAILING Address Information: Include mailing address, street, city, county, state, and zip code): 301 Jackson Street, HHS – Clinical Health Services Richmond, Texas 77469	
Check if address change <input checked="" type="checkbox"/>	
3) PAYEE Name and Mailing Address (if different from above): Fort Bend Co.Auditors Office, 301 Jackson St. Richmond Texas 77469	
Check if address change <input type="checkbox"/>	
4) DUNS Number (9 digit) required if receiving American Recovery and Reinvestment Act of 2009 (ARRA) funds: 08-149-7075	
5) Federal Tax ID no. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) of Social Security Number (9 digit): 746001969	
<small>*The contractor acknowledges, understands and agrees that the contractor'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>	
6) TYPE OF ENTITY (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>	
7) PROPOSED BUDGET PERIOD: Start Date: September 1, 2018 End Date: August 31, 2019	
8) COUNTIES SERVED BY PROJECT: Fort Bend County	
9) AMOUNT OF FUNDING REQUESTED: \$258,364.00	11) PROJECT CONTACT PERSON
10)PROJECTED EXPENDITURES Does contractor's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for contractors current fiscal year (excluding amount requested in line 9 above)?**  Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Name: Ngombe Bitendelo, CHS Director Phone: 281-238-3548 Fax: 281-342-7371 Email: ngombe.bitendelo@fortbendcountytexas.gov
**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	12) FINANCIAL OFFICER  Name: Ed Sturdivant Phone: 281-341-3760 Fax: 281-341-3374 Email: Ed.Sturdivant@fortbendcountytexas.gov
The facts affirmed by me in this proposal are truthful and I warrant the contractor is in compliance with assurances and certifications contained in APPENDIX A: DSHS Assurances and Certification. 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 contractor and I (the person signing below) am authorized to represent the contractor.	
13) AUTHORIZED REPRESENTATIVE Check if change <input type="checkbox"/> Name: Robert E. Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-8609 Email: county.judge@fortbendcountytexas.gov	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE 
15) DATE 1/9/2018	

## FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the contractor and the proposed project with the Department of State Health Services (DSHS), including the signature of the authorized representative. It is the cover page of the renewal and is required to be completed. Signature affirms the facts contained in the contractor's response are truthful and the contractor is in compliance with the assurances and certifications contained in **APPENDIX A: DSHS Assurances and Certifications** and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below to complete the face page form and return with the contractor's renewal application.

- 1) **LEGAL BUSINESS NAME** - Enter the legal name of the contractor.
- 2) **MAILING ADDRESS INFORMATION** - Enter the contractor's complete physical address and mailing address, city, county, state, and zip code.
- 3) **PAYEE NAME AND MAILING ADDRESS** - Payee – Entity involved in a contractual relationship with contractor to receive payment for services rendered by contractor and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address if PAYEE is different from the contractor. The PAYEE is the corporation, entity or vendor who will be receiving payments.
- 4) **DUNS Number** – 9 digit Dun and Bradstreet Data Universal Numbering System (DUNS) number or Central Contractor Registration number plus 4 digit extended DUNS number. This number is required if receiving **ANY** American Recovery and Reinvestment Act (ARRA) funds and can be obtained at: <http://fedgov.dnb.com/webform>
- 5) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID/SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit). \*The contractor acknowledges, understands and agrees the contractor'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 the type of entity as defined by the Secretary of State at <http://www.sos.state.tx.us/corp/businessstructure.shtml> or <http://www.sos.state.tx.us/corp/nonprofit.org.shtml> and/or the Texas State Comptroller at [https://fmxcpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS\\_Guide\\_0409.pdf](https://fmxcpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf) and check all other boxes that describe the entity.  
  
Historically Underutilized Business: A minority or women-owned business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. (<http://www.window.state.tx.us/procurement/prog/hub/>)  
State Agency: an agency of the State of Texas as defined in Texas Government Code §2056.001.ii  
Institutions of higher education as defined by §61.003 of the Education Code.  
MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.  
If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.
- 7) **PROPOSED BUDGET PERIOD** - Enter the budget period for this proposal. Budget period is 09/01/2013 – 08/31/2014.
- 8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.
- 9) **AMOUNT OF FUNDING REQUESTED** - Enter the amount of funding requested from DSHS for proposed project activities (not including possible renewals). This amount must match column (1) row K from the BUDGET SUMMARY used for cost reimbursement budgets.
- 10) **PROJECTED EXPENDITURES** - If contractor's projected federal expenditures exceed \$500,000 or its projected state expenditures exceed \$500,000 for contractor's current fiscal year, contractor must arrange for a financial compliance audit (Single Audit).
- 11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and email address of the person responsible for the proposed project.
- 12) **FINANCIAL OFFICER** - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.
- 13) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and email address of the person authorized to represent the contractor. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.
- 14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the contractor must sign in this blank.
- 15) **DATE** - Enter the date the authorized representative signed this form.



## FORM B: TABLE OF CONTENTS AND CHECKLIST

Legal Business Name of  
Contractor: \_\_\_\_\_

*This form is provided as your Table of Contents and to ensure the proposal is complete, proper signatures are included, and the required assurances, certifications, and attachments have been submitted. Be sure to indicate page number.*

FORM	DESCRIPTION	Included	Page #	Not Applicable
A	Face Page - completed, and proper signatures and date included	<input type="checkbox"/>		
A-1	Texas Counties and Regions List	<input type="checkbox"/>		
B	Table of Contents and Checklist – completed and included	<input type="checkbox"/>		
C	Contact Person Information – completed and included	<input type="checkbox"/>		
D	Job Descriptions (with supplemental documentation attached if required)	<input type="checkbox"/>		
E	Program Income Spending Page	<input type="checkbox"/>		
F	Work Plan – included	<input type="checkbox"/>		
I	Budge Summary Form and Detail Pages	<input type="checkbox"/>		
Appendix B	Copy of Approved Indirect Rate – included (if applicable)	<input type="checkbox"/>		

## FORM C: CONTACT PERSON INFORMATION

**Legal Business Name of Contractor:**

Fort Bend County Clinical Health Services

*This form provides information about the appropriate contacts in the contractor's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the **Contract Management Section**.*

**Contacts must include, but are not limited to: Executive Director, Financial Contact, Program Contact, and Emergency Contact information.**

<b>Contact:</b>	Ngombe Bitendelo	<b>Mailing Address</b>	
<b>Title:</b>	Director	<b>Street:</b>	4520 Reading Rd. Ste. A #200
<b>Phone:</b>	281-238-3548	<b>City:</b>	Rosenberg
<b>Fax:</b>	281-342-7371	<b>County:</b>	Fort Bend
<b>Email:</b>	Ngombe.Bitendelo@fortbendcountytexas.gov	<b>State, Zip:</b>	TX 77471
<b>Contact:</b>	Robert Castaneda	<b>Street:</b>	4520 Reading Rd. Ste. A #200
<b>Title:</b>	IPOS/TVFC	<b>City:</b>	Rosenberg
<b>Phone:</b>	281-238-3590 <b>Ext:</b>	<b>County:</b>	Fort Bend
<b>Fax:</b>	281-238-3564	<b>State, Zip:</b>	TX 77471
<b>Email:</b>	Robert.Castaneda@fortbendcountytexas.gov		
<b>Contact:</b>	Kaye Reynolds, DrPH	<b>Street:</b>	4520 Reading Rd. Ste. A #200
<b>Title:</b>	Deputy Director/ Project Financial Contact	<b>City:</b>	Rosenberg
<b>Phone:</b>	281-238-3519 <b>Ext:</b>	<b>County:</b>	Fort Bend
<b>Fax:</b>	281-342-3355	<b>State, Zip:</b>	TX 77471
<b>Email:</b>	Kaye.Reynolds@fortbendcountytexas.gov		
<b>Contact:</b>	Cynthia Smith	<b>Street:</b>	4520 Reading Rd. Ste. A #200
<b>Title:</b>	Administrative Assistant	<b>City:</b>	Rosenberg
<b>Phone:</b>	281-238-3558 <b>Ext:</b>	<b>County:</b>	Fort Bend
<b>Fax:</b>	281-342-7371	<b>State, Zip:</b>	TX 77471
<b>Email:</b>	Cynthia.Smith@fortbendcountytexas.gov		
<b>Emergency Contact:</b>		<b>Street:</b>	
<b>Title:</b>		<b>City:</b>	
<b>Phone:</b>	<b>Ext:</b>	<b>County:</b>	
<b>Fax:</b>		<b>State, Zip:</b>	
<b>Email:</b>			

## FORM D: JOB DESCRIPTIONS

Please insert job descriptions here for all positions listed on the Personnel Detail which were not listed last year. Also include any job description that was updated during fiscal year 2018.



## Form E: PROGRAM INCOME SPENDING PLAN

Projected amount of the DSHS share of Program Income (from page 30, Budget Summary, Line K, Row 2)  
\$

Please forecast how DSHS' share of Program income will be used. This money is available for immunization activities in addition to contract funds. Throughout the year, LHDs are responsible for monitoring program income collections to assure that projections are being met prior to expending funds as described below. Use of these funds is subject to the same restrictions as apply to grant funds.

Cost Categories	Funds Projected	Purpose and Justification
A. Personnel	\$	
B. Fringe Benefits	\$	
C. Travel	\$	
D. Supplies	\$	
E. Contractual	\$	
F. Other	\$	
Total (DSHS Share Program Income)	\$	

## Regional Program Managers FY 2019

### HEALTH SERVICE REGION 1

Leigh Johnston  
Immunization Program Manager  
6302 Iola Ave.  
Lubbock, Texas 79424  
(806) 783-6412  
(806) 783-6435 – Fax

[Leigh.Johnston@dshs.texas.gov](mailto:Leigh.Johnston@dshs.texas.gov)

### HEALTH SERVICE REGIONS 2 & 3

Cheryl Millican  
Immunization Program Manager  
1301 South Bowen Road, Suite 200  
Arlington, Texas 76013-2262  
(817) 264-4795  
(817) 264-4800 – Fax

[Cheryl.Millican@dshs.texas.gov](mailto:Cheryl.Millican@dshs.texas.gov)

### HEALTH SERVICE REGIONS 4 & 5 NORTH

Tammie Little  
Immunization Program Manager  
1517 W. Front Street  
Tyler, Texas 75702  
(903) 533-5310  
(903) 533-9502 - Fax

[Tammie.Little@dshs.texas.gov](mailto:Tammie.Little@dshs.texas.gov)

### HEALTH SERVICE REGIONS 6 & 5 SOUTH

Sabrina Stanley  
Immunization Program Manager  
5425 Polk, Suite J  
Houston, Texas 77023  
(713) 767-3454  
(713) 767-3889 - Fax

[Sabrina.Stanley@dshs.texas.gov](mailto:Sabrina.Stanley@dshs.texas.gov)

### HEALTH SERVICE REGION 7

Debbie Shelton  
Immunization Program Manager  
2408 South 37th Street  
Temple, Texas 76504-7168  
(254) 778-6744  
(254) 771-2612 - Fax

[Debbie.Shelton@dshs.texas.gov](mailto:Debbie.Shelton@dshs.texas.gov)

### HEALTH SERVICE REGION 8

Laurie Henefey  
Immunization Program Manager  
112 Joe Carper Drive  
Uvalde, Texas 78801  
(830) 591-4386 Extension 213  
(830) 278-1831 - Fax

[Laurie.Henefey@dshs.texas.gov](mailto:Laurie.Henefey@dshs.texas.gov)

### HEALTH SERVICE REGIONS 9 & 10

Donna Anders  
Immunization Program Manager  
2301 N. Big Spring #300  
Midland, Texas 79705-7649  
(432) 571-4137  
(432) 571-4190 - Fax

[Donna.Anders@dshs.texas.gov](mailto:Donna.Anders@dshs.texas.gov)

### HEALTH SERVICE REGION 11

Rebecca Lopez  
Immunization Program Manager  
601 W. Sesame Drive  
Harlingen, Texas 78550  
(956) 421-5553  
(956) 443-3216 - Fax

[Rebecca.Lopez@dshs.texas.gov](mailto:Rebecca.Lopez@dshs.texas.gov)