Inter-Local Application For Tuberculosis Prevention and Control for FY 2019 State Funds

http://www.dshs.state.tx.us/idcu/disease/tb

TB Services Branch

1100 W. 49th Street
P. O. Box 149347, MS 1990
Austin, Texas 78714

TABLE OF CONTENTS

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** ☐
HHS – Clinical Health Services, 301 Jackson Street, Richmond, TX 77469

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:** 081497075

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:** 09/01/2018 **End Date:** 08/31/2019

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

9) **AMOUNT OF FUNDING REQUESTED:** $134,397

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, Dr PH
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** ☐

Name: Robert Hebert
Title: County Judge
Phone: 281-341-8608
Fax: 281-341-8609
Email: county.judge@fortbendcountytx.gov

14) **DATE**

DOCUSIGN SIGNATURE INFORMATION	
15) DOCUSIGN - SIGNATURE AUTHORITY Name: Robert E. Hebert Email Address: county.judge@fortbendcountytx.gov Documents to Sign: Signature Page X☐ Data Use Agreement X☐	**16) DOCUSIGN - SECONDARY SIGNATURE AUTHORITY** Name: Email Address: (this email address must be different from the Signature Authority email address) Documents to Sign: Signature Page ☐ Data Use Agreement ☐

FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the respondent 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 proposal and is required to be completed. Signature affirms the facts contained in the respondent's response are truthful and the respondent is in compliance with the assurances and certifications contained in **APPENDIX B: 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 respondent's proposal.

1) **LEGAL BUSINESS NAME** - Enter the legal name of the respondent.

2) **MAILING ADDRESS INFORMATION** - Enter the respondent's complete physical address and mailing address, city, county, state, and 9-digit zip code.

3) **PAYEE NAME AND MAILING ADDRESS** - Payee – Entity involved in a contractual relationship with respondent to receive payment for services rendered by respondent and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address, including 9-digit zip code, if PAYEE is different from the respondent. 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. . This number is required if receiving **ANY** federal funds and can be obtained at: http://fedgov.dnb.com/webform

5) **FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The respondent acknowledges, understands and agrees the respondent's choice to use a social security number as its 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 and/or the Texas State Comptroller at https://fmx.cpa.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 defined in the RFP.

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 respondent's projected federal expenditures exceed $500,000 or its projected state expenditures exceed $500,000 for respondent's current fiscal year, respondent 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 respondent. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

14) **DATE** - Enter the date the authorized representative signed this form.

15) **DOCUSIGN SIGNATURE AUTHORITY** – Enter the name, email address, and list the contract documents of the person authorized to sign the contract via DocuSign.

16) **DOCUSIGN SECONDARY SIGNATURE AUTHORITY** –If a Secondary Signature Authority exists, enter the name, email address, and list the contract documents of the person authorized to sign via DocuSign. Please ensure the email address listed for the Secondary Signature Authority is different from the email address for the Signature Authority in Box # 16.

FORM B: Inter-Local APPLICATION CHECKLIST

Legal Name of applicant: Fort Bend County

This form is provided to ensure that the application is complete, proper signatures are included, and the required assurances, certifications, and attachments have been submitted.

FORM	DESCRIPTION	Included
A	Face Page completed, and proper signatures and date included	X
B	Application Checklist completed and included	X
C	Contact Person Information completed and included	X
D	Administrative Information completed and included (with supplemental documentation attached if required)	X
E	Organization, Resources and Capacity included	X
F	Performance Measures included	X

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 Unit.***

Contact:	Ngombe Bitendelo, RN,BSN,MPH	**Mailing Address (incl. street, city, county, state, & zip):**
Title:	FBCHHS Director	4520 Reading Road, Suite A-200
Phone:	281-238-3548	Rosenberg, Texas 77471
Fax:	832-471-1808	
E-mail:	Ngombe.bitendelo@fortbendcountytx.gov	

Contact:	Kaye Reynolds, DrPH	**Mailing Address (incl. street, city, county, state, & zip):**
Title:	FBCHHS Deputy Director	4520 Reading Road, Suite A-100
Phone:	281-238-3519	Rosenberg, Texas 77471
Fax:	832-471-1808	
E-mail:	Kaye.Reynolds@fortbendcountytx.gov	

Contact:	Patsy Landin, RN	**Mailing Address (incl. street, city, county, state, & zip):**
Title:	TB/HIV/STD Program Manager	4520 Reading Road, Suite A-200
Phone:	281-238-3547	Rosenberg, Texas 77471
Fax:	832-471-1818	
E-mail:	Patsy.Landin@fortbendcountytx.gov	

FORM D: ADMINISTRATIVE INFORMATION - ILA

This form provides information regarding identification and contract history on the applicant, executive management, project management, governing board members, and/or principal officers. Respond to each request for information ***or provide the required supplemental document behind this form.*** *If responses require multiple pages, identify the supporting pages/documentation with the applicable request.*

Legal Name of Applicant: Fort Bend County

Identifying Information

The applicant shall complete the following information:

- Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the applicant.

Last Name:	Hebert	**Mailing Address (incl. street, city, county, state, & zip):**
First Name:	Robert	Office of the County Judge
Middle Name:		301 Jackson Street, Richmond, TX 77469
Last Name :		**Mailing Address (incl. Street, city, county, state, & zip) :**
First Name :		
Middle Name :		

Conflict of Interest and Contract History

The applicant shall disclose any existing or potential conflict of interest relative to the performance of the requirements of this Application for Funding. Examples of potential conflicts may include an existing business or personal relationship between the applicant, its principal, or any affiliate or subcontractor, with DSHS, the participating agencies, or any other entity or person involved in any way in any project that is the subject of this Application for Funding. Similarly, any personal or business relationship between the applicant, the principals, or any affiliate or subcontractor, with any employee of DSHS, a participating agency, or their respective suppliers, must be disclosed. Any such relationship that might be perceived or represented as a conflict shall be disclosed. Failure to disclose any such relationship may be cause for contract termination or disqualification of the proposal. If, following a review of this information, it is determined by DSHS that a conflict of interest exists, the applicant may be disqualified from further consideration for the award of a contract.

1. **Does anyone in the applicant organization have an existing or potential conflict of interest relative to the performance of the requirements of this Application for Funding?**

   ☐ **YES** **NO** ☒

   If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)

2. **Has any member of applicant's executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the application due date?**

   ☐ **YES** **NO** ☒

   If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation.

FORM D: ADMINISTRATIVE INFORMATION – ILA - continued

3. **Has applicant had a contract with DSHS within the past 24 months?**

☒ **YES** ☐ **NO**

If YES, indicate the contract number(s):

Contract Number(s)	
Contract Number	**Grant**
2016-004093-03	HIV Prevention
IDCUSURFY18&FY19	Disease surveillance
HHS000036000004	TB Program federal
537-18-0034-00001	TB Program state
537-18-0056-00001	Immunization Program

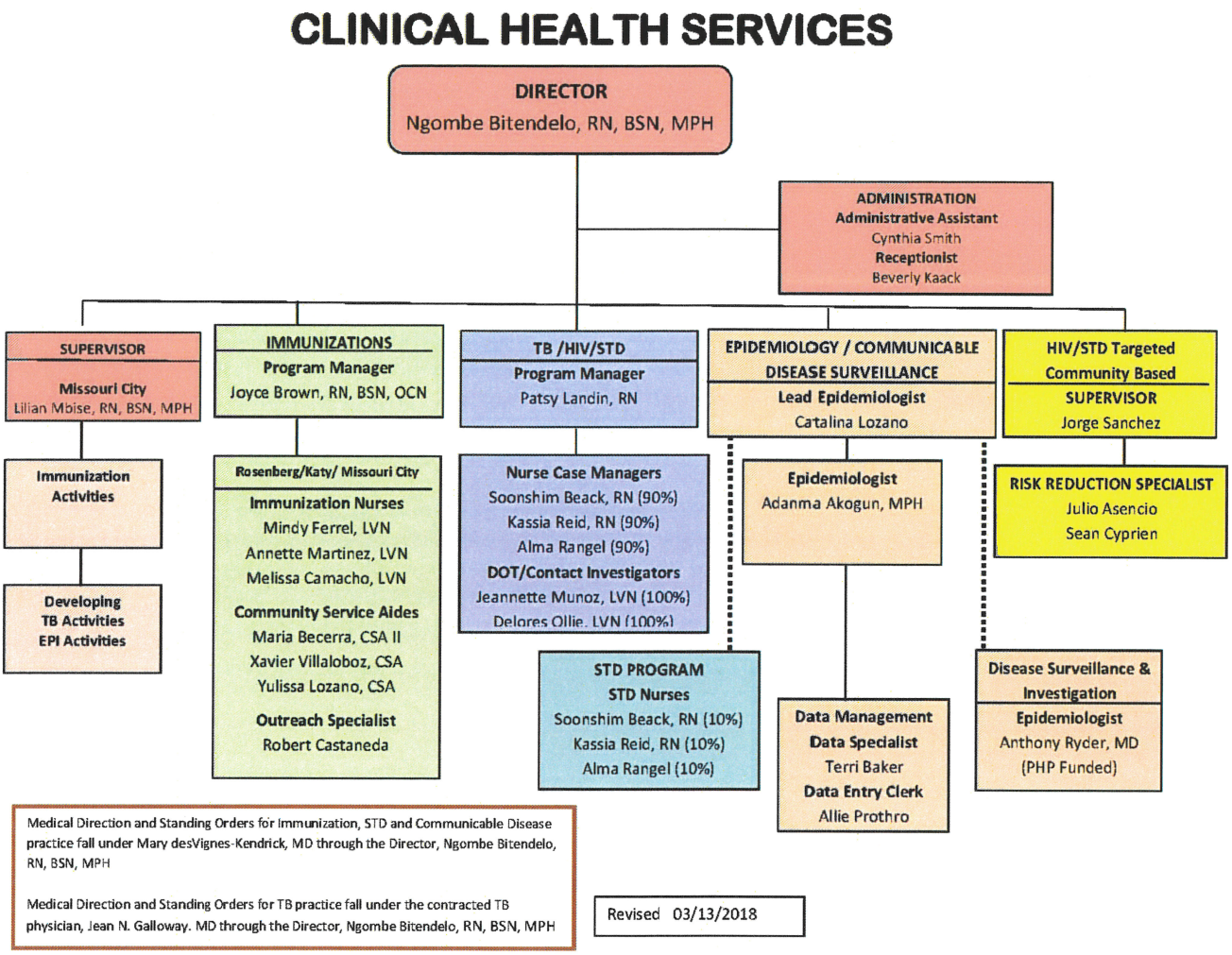
If NO, applicant must be able to demonstrate fiscal solvency. Submit a copy of the organization's most recently audited balance sheet, statement of income and expenses and accompanying financial footnotes DSHS will evaluate the documents that are submitted and may, at its sole discretion, reject the proposal on the grounds of the applicant's financial capability.

4. **Is applicant or any member of applicant's executive management, project management, board members or principal officers:**
   - Delinquent on any state, federal or other debt;
   - Affiliated with an organization which is delinquent on any state, federal or other debt; or
   - In default on an agreed repayment schedule with any funding organization?

☐ **YES** **NO** ☒

If YES, please explain. (Attach no more than one additional page.)

FORM E: ORGANIZATION, RESOURCES AND CAPACITY
(Organizational Chart)



FORM F: PERFORMANCE MEASURES

In the event a contract is awarded, applicant agrees that performance measures will be used to assess, in part, the applicant's effectiveness in providing the services described.

Please refer to the work plan located at the following web link:
http://www.dshs.texas.gov/idcu/disease/tb/policies/

Contractor shall maintain documentation used to calculate performance measures as required by General Provisions Article VIII "Records Retention" and by Texas Administrative Code Title 22, Part 9 Chapter 165, §165.1 regarding retention of medical records.

All reporting to DSHS shall be completed as described in Section I, "D. Reporting" and submitted by the deadlines given.

If Contractor fails to meet any of the performance measures, Contractor shall furnish in the Annual Progress Report, **due April 10, 2019**, a written narrative explaining the barriers and the plan to address those barriers. This requirement does not excuse any violation of this Contract, nor does it limit DSHS as to any options available under the contract regarding breach.

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: Fort Bend County Clinical Health Services

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	$117,959	$91,080			$26,879	
B. Fringe Benefits	$40,465	$40,465			$0	
C. Travel	$452	$452			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$0	$0			$0	
F. Contractual	$2,400	$2,400			$0	
G. Other	$0	$0			$0	
H. Total Direct Costs	$161,276	$134,397	$0	$0	$26,879	$0
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$161,276	$134,397	$0	$0	$26,879	$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**	**$117,959**	**$117,959**	**Fringe Benefits**	**$40,465**	**$40,465**
	Travel	**$452**	**$452**	**Equipment**	**$0**	**$0**
	Supplies	**$0**	**$0**	**Contractual**	**$2,400**	**$2,400**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$161,276**	**Budget Total**	**$161,276**

*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 (Match)

Legal Name of Respondent: Fort Bend County Clinical Health Services

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/HIV/STD Case Manager	N	Case management of TB patients, medication management with TB physician, cohort review, VDOT patient enrollment, training, monitoring	0.42	RN	$2,239.92	12	$26,879
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$26,879

FRINGE BENEFITS Itemize the elements of fringe benefits in the space below:

	Fringe Benefit Rate %	
	Fringe Benefits Total	$0