



FY2020
COVID - 19

Applicant Information

Legal Name of Agency:
Mailing Address:

Fort Bend County

Street / PO Box: Health & Human Services - 301 Jackson St.
City: Richmond, TX
Zip: 77469

Payee Name:

Same

Payee Mailing Address:

Street / PO Box: Same
City:
Zip:

State of Texas Comptroller Vendor ID #
(11 digit + 3 digit mail code):

1 746001969 055

DUNS # (9 digits required for subrecipient contracts):

08-14-97075

Fiscal Year-End Date (MM/DD)

Type of Entity (Choose one)

- City: Click on appropriate box
- County:
- Other Political Subdivision:
- Nonprofit Organization
- Community-Based Organization
- Hospital
- State Controlled Institution of Higher Learning
- Other
- Faith Based (Nonprofit Org)

Contract Term:

Start Date: 12/1/2019
End Date: 8/31/2020

State-wide or Counties Served

State-wide or County(ies) Served:

Fort Bend

Amount of Funding Allocated:

\$436,091.00

Minimum Unduplicated Clients to be Served



CONTACT PERSON INFORMATION

Legal Business Name:

This form provides information about the appropriate contacts in the contractor's organization. If any of the following information changes during the term of the contract, please send written/e-mail notification to the Assigned Contract Manager.

Health Director / CEO / Executive Director:
Direct Phone: Ext:
E-mail:

Mailing Address (street, city, county, & zip):

B-13 Submitter:
Direct Phone: Ext:
E-mail:

Mailing Address (street, city, county, & zip):

Program Lead Person:
Direct Phone: Ext:
E-mail:

Mailing Address (street, city, county, & zip):

Contract Lead Person:
Direct Phone: Ext:
E-mail:

Mailing Address (street, city, county, & zip):

Contract Authorized Signatory:
Direct Phone: Ext:
E-mail:

Mailing Address (street, city, county, & zip):

Additional Contract Authorized Signatory:
Direct Phone: Ext:
E-mail:

Mailing Address (street, city, county, & zip):

FFATA/Assurances Signatory:
Direct Phone: Ext:
E-mail:

Mailing Address (street, city, county, & zip):

BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent:

Fort Bend County

Budget Categories	TOTAL BUDGET	DSHS Funds Requested (Allocation Amount)
A. Personnel	\$0	\$0
B. Fringe Benefits	\$0	\$0
C. Travel	\$0	\$0
D. Equipment	\$0	\$0
E. Supplies	\$0	\$0
F. Contractual	\$436,091	\$436,091
G. Other	\$0	\$0
H. Total Direct Costs	\$436,091	\$436,091
I. Indirect Cost Rate Amount	\$0	\$0
J. Total (Sum of H and I)	\$436,091	\$436,091

Direct Federal Funds	
Other State Agency Funds	
Local Funding Sources	
Other Funds	
Contract Total	\$436,091.00

TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Fort Bend County

Conference / Workshop Travel Costs						
Description of Conference/Workshop	Justification	Location City/State	Number of:		Travel Costs	
			Days	Employees		
					Mileage	
					Airfare	
					Meals	
					Lodging	
					Other Costs	
					Total	\$0
					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 \$0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			\$0		\$0
			\$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

CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: **Fort Bend County**

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates \$100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Payments	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL COST
Angel Staffing or other vendor to be determined	RNs, LVNs, or other professional staff to conduct epidemiological contact investigation, contact tracing and reporting	to supplement existing staff with the increasing COVID 19 case load.	Lump Sum	1	#####	\$361,091
Staffing Solutions or other vendor to be determined	Compilation and analysis of COVID 19 data.	to assist with data collection and analysis and improve the quality of data for reporting purposes.	Lump Sum	1	\$75,000.00	\$75,000
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL: **\$436,091**

OTHER COSTS Budget Category Detail Form

Legal Name of Respondent:

Fort Bend County

Description of Item <small>Include quantity and cost/quantity</small>	Purpose & Justification	Total Cost
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$0

Indirect Cost Rate

Legal Name of Respondent:

Fort Bend County

Total amount of indirect costs allocable to the project:

Amount:

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 (Indirect Costs)**

RATE:
BASE:

I attest that I have not had an approved indirect cost rate and I am requesting/electing to utilize the de minimis indirect cost rate.

I elect not to request indirect costs.

SUPPLEMENTAL FORMS INSTRUCTION

The budget templates (two 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. Applicants that have utilized all the lines on the primary budget template must use the supplemental templates to list detail information for the respective budget category. For example, after all the lines on the primary budget template for Personnel (tab labeled Form I - 1 Personnel) have been used, go to the supplemental template labeled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labeled "Form I - 1b Personnel". The amounts on each supplemental template will automatically total and the total from both templates will automatically be inserted on the last line of the primary budget template.

The supplemental budget templates are:

Personnel Supplemental
Travel Supplemental
Equipment & Controlled Assets Supplemental
Supplies Supplemental
Contractual Supplemental
Other Costs Supplemental

TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)	Number of: Days & Employees	Travel Costs	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0

Total for Conference / Workshop Travel

\$0

Other / Local Travel Costs

	Number of	Mileage	
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Justification	Miles	Mileage Reimbursement Rate	Cost (a)	Other Costs (b)	Total (a) + (b)
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0

Total for Other / Local Travel

Other / Local Travel Costs:

Conference / Workshop Travel Costs:

Total Travel Costs:

