

FORT BEND COUNTY FY 2009
COMMISSIONERS COURT AGENDA REQUEST FORM
Return Completed Form to: Agenda Coordinator, County Judge's Office

Date Submitted: April 28, 2009 Submitted By: Nancy Drake, R.N., Director
Department: Clinical Health Services
Court Agenda Date: May 5, 2009 Phone Number: 281.238.3548

SUMMARY OF ITEM: Application to DSHS for Immunization Grant. FY2010. Total amount \$ 258,364.00 No matching funds.
RENEWAL AGREEMENT/APPOINTMENT: YES NO X
REVIEWED BY COUNTY ATTORNEY'S OFFICE: YES NO X
List Supporting Documents Attached: Inter-Local Application for Immunization Program FY 2010.

FINANCIAL SUMMARY:
BUDGETED ITEM: YES NO X
FUNDNG SOURCE: Fund: Agency: Organization: Object:
REQUIRES AUDITOR TO CERTIFY FUNDS: YES X NO

Instructions to submit Agenda Request Form:
• Completely fill out agenda form: incomplete forms will not be processed.
• Agenda Request Forms may be submitted by e-mail, fax, or inter-office mail, and all back-up information must be provided by Wednesday at 2:00 p.m. to all those listed below.
• All original back-up must be received in the County Judge's Office by 2:00 p.m. on Wednesday.
DISTRIBUTION:
Original Form Submitted with back up to County Judge's Office (✓ when completed)
If by E-Mail to ospindon@co.fort-bend.tx.us If by Fax to (281) 341-8609
Distribute copies with back-up to all listed below. If by fax, send to numbers below:

<input type="checkbox"/> Auditor (281-341-3774)	<input type="checkbox"/> Comm. Pct. 1 (281-342-0587)
<input type="checkbox"/> Budget Officer (281-344-3954)	<input type="checkbox"/> Comm. Pct. 2 (281-403-8009)
<input type="checkbox"/> Facilities/Planning (281-633-7022)	<input type="checkbox"/> Comm. Pct. 3 (281-242-9060)
<input type="checkbox"/> Purchasing Agent (281-341-8642)	<input type="checkbox"/> Comm. Pct. 4 (281-980-9077)
<input type="checkbox"/> Information Technology (281-341-4526)	<input checked="" type="checkbox"/> County Clerk (281-341-8697)
<input type="checkbox"/> Other:	<input type="checkbox"/> County Atty (281-341-4557)

RECOMMENDATION / ACTION REQUESTED:

Special Handling Requested (specify):



Department of State Health Services

FORM A: FACE PAGE

Proposal for Financial Assistance

This form requests basic information about the respondent and project, including the signature of the authorized representative. The face page is the cover page of the proposal and must be completed in its entirety.

RESPONDENT INFORMATION																			
1) LEGAL BUSINESS NAME: Fort Bend County Clinical Health Services																			
2) MAILING Address Information (include mailing address, street, city, county, state and zip code): Check if address change <input type="checkbox"/> Fort Bend County 4520 Reading Rd. – Ste. A Rosenberg, TX 77471																			
3) PAYEE Name and Mailing Address (if different from above): Check if address change <input type="checkbox"/> Fort Bend County Auditor																			
4) Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or Social Security Number (9 digit): [REDACTED]																			
<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>																			
5) 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"/> FQHC</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"/> FQHC	<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): _____
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	<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>																			
6) PROPOSED BUDGET PERIOD: Start Date: September 1, 2009 End Date: August 31, 2010																			
7) COUNTIES SERVED BY PROJECT: Fort Bend County																			
8) AMOUNT OF FUNDING REQUESTED: \$258,364.00	10) PROJECT CONTACT PERSON Name: Nancy Drake, R.N. Phone: 281-238-3548 Fax: 281-342-7371 E-mail: drakenan@co.fort-bend.tx.us																		
9) PROJECTED EXPENDITURES Does respondent's projected state or federal expenditures exceed \$500,000 for respondent's current fiscal year (excluding amount requested in line 8 above)? ** Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>**Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.</i>																			
11) FINANCIAL OFFICER Name: Ed Sturdivant Phone: 281-341-3760 Fax: 281-341-3374 E-mail: sturdrob@co.fort-bend.tx.us																			
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 A: 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.																			
12) AUTHORIZED REPRESENTATIVE Check if change <input type="checkbox"/>	13) SIGNATURE OF AUTHORIZED REPRESENTATIVE																		
Name: Robert Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-6809 E-mail: hebertb@co.fort-bend.tx.us																			
14) DATE 04/28/09																			