15A

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

Date Submitted: July 14, 2009
Court Agenda Date: July 21, 2009

Submitted By: Nancy Drake, R.N.,Director
Department: Clinical Health Services
Phone Number: 281.238.3548

SUMMARY OF ITEM: Department of State Health Services Renewal Application FY2010 for Tuberculosis Control in the amount of $ 174,826.00, no matching County funds.

RENEWAL AGREEMENT/APPOINTMENT YES X NO ☐
REVIEWED BY COUNTY ATTORNEY'S OFFICE: YES ☐ NO X

List Supporting Documents Attached: Application

FINANCIAL SUMMARY:

BUDGETED ITEM: YES ☐ NO x

FUNDNG SOURCE: Accounting Unit: 100630999 Account Number:
Activity (If Applicable): G630-09TUBERCUL

DESCRIPTION OF LAWSOM ACCOUNT: _____

Instructions to submit Agenda Request Form:

- Completely fill out agenda form: incomplete forms will not be processed.
- Agenda Request Forms should 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 X (✓ 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:

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

RECOMMENDATION / ACTION REQUESTED:

Special Handling Requested (specify):

TEXAS Department of State Health Services

Department of State Health Services (DSHS)
FORM A: FACE PAGE – Inter-Local
Application for Financial Assistance

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

APPLICANT INFORMATION

1) LEGAL 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 ☐

Fort Bend County Clinical Health Services
4520 Reading Road, Ste A
Rosenberg, TX 77471

3) PAYEE Mailing Address (if different from above):

Fort Bend County Auditor
301 Jackson St.reet, Ste 533
Richmond, TX 77469

Check if address change ☐

4) Federal Tax ID No. (9 digit) or **State of Texas Comptroller Vendor ID No.** (14 digit) [redacted]

5) TYPE OF ENTITY (check all that apply):

- ☐ City
- ☒ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

**If incorporated, provide 10-digit charter number assigned by Secretary of State:*

6) HUB REQUIREMENTS:

Are you a governmental body bound by HUB or MWBE (Minority & Women's Business Enterprise) mandates/requirements? ☐ Yes ☒ No

If "Yes", no further action is required. **If "No", contact the DSHS HUB Coordinator at 1-800-243-7487 or by e-mail at** HUB-Contact@dshs.state.tx.us.

7) PROPOSED BUDGET PERIOD: **Start Date:** 09/01/2009 **End Date:** 08/31/2010

8) COUNTIES SERVED BY PROJECT:

Fort Bend County

9) AMOUNT OF FUNDING REQUESTED: $174,826

10) PROJECTED EXPENDITURES

Does applicant's projected state or federal expenditures exceed $500,000 for applicant's current fiscal year (excluding amount requested in line 8 above)? **

Yes ☒ No ☐

***Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.*

11) PROJECT CONTACT PERSON

Name: Nancy Drake, RN
Phone: 281-238-3548
Fax: 281-342-7371
E-mail: drakenan@co.fort-bend.tx.us

12) FINANCIAL OFFICER

Name: Robert E. Sturdivant
Phone: 281-344-3760
Fax: 281-341-3774
E-mail: sturdrob@co.fort-bend.tx.us

The facts affirmed by me in this Application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in **APPENDIX A: DSHS Assurances and Certifications**. I understand that 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 applicant and I (the person signing below) am authorized to represent the applicant.

13) AUTHORIZED REPRESENTATIVE Check if change ☐

Name: Robert E. Hebert
Title: County Judge
Phone:: 281-341-8608
Fax: 281-341-8609
E-mail: hebertb@co.fort-bend.tx.us

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

15) DATE

07/14/09