

**Renewal InterLocal Application
for
Immunization Program Funds
Fiscal Year 2013**

www.ImmunizeTexas.com

Issue date:03/19/2012

Due date: 04/13/2012

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

4-3-12 copy received

I. INTRODUCTION

The Department of State Health Services (DSHS) Immunization Branch announces the expected availability of Fiscal Year (FY) 2013 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 original and two (2) copies of the completed renewal application by mail to the Department of State Health Services, Contract Management Unit, MC 1990, P.O. Box 149347, Austin, Texas 78714 with Attn: Dianna Highberg, on or before April 13, 2012. An additional copy of the renewal application must be submitted electronically to DSHSImmuneContracts@dshs.state.tx.us if your email is returned for any reason contact Dianna Highberg at 512.776.2178 and/or resubmit your electronic copy to dianna.highberg@dshs.state.tx.us. Renewal applications received after this deadline will not be considered for funding.

Apply for level funding. There are no additional funds available at this time.

The renewal application now includes a form for Indirect Costs (I-7). 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 Branch 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.

A copy of the revised Work Plan for Fiscal Year 2013 is also attached for your reference.

II. APPLICATION POINT OF CONTACT

For purposes of addressing questions concerning this Application, the only contact is Dianna Highberg of the Contract Management Unit unless otherwise delegated by the CSCU Director. All communications concerning this Application must be addressed by email or fax to:

Mailing Address for Regular Mail:
Dianna Highberg, Contract Manager,
Contract Management Unit MC1990
Department of State Health Services
P.O. Box 149347
Austin, Texas 78714-9347

Physical Address for Overnight Mail:
Dianna Highberg, Contract Manager,
Contract Management Unit
Department of State Health Services
1100 West 49th Street, W-239
Austin, Texas 78756

Phone and Fax Numbers:
512.776.2178
512.776.7391 fax

CMU Contact Email:
Dianna.highberg@dshs.state.tx.us

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 B. Application Table of Contents and Checklist
- Form C. Contact Person Information
- Form D. Job Descriptions (if applicable)
- Form E. Program Income Spending Plan
- Forms F-H Not applicable for this contract
- Form I. Budget (see separate file)
- Exhibit A. FY2013 Work Plan
- Appendix A. DSHS Assurances and Certifications
- Appendix B. Copy of Approved Indirect Rate (if applicable)

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.

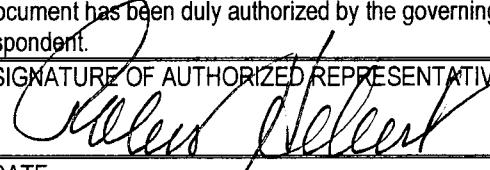
- 1) **LEGAL BUSINESS NAME**-Enter the legal name of the respondent.
- 2) **MAILING ADDRESS INFORMATION**-Enter the respondent's complete physical address and mailing address, city, county, state, and zip code.
- 3) **PAYEE NAME AND MAILING ADDRESS**-Payee – Entity involved in a contractual relationship 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 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 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 respondent acknowledges, understands and agrees 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 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 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) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the respondent must sign in this blank.
- 15) **DATE** - Enter the date the authorized representative signed this form.

Department of State Health Services
FROM A: FACE PAGE PAGE 1

Proposal for Financial Assistance [ILA Number]

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): Fort Bend County 4520 Reading Rd. – Ste. 200, Rosenberg, TX 77471	
Check if address change <input type="checkbox"/>	
3) PAYEE Name and Mailing Address (if different from above) Fort Bend County Auditors 301 Jackson St. – Ste. 533, Richmond, TX 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:	
5) Federal Tax ID no. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) of Social Security Number (9 digit): 746001969	
<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>	
6) TYPE OF ENTITY (check all that apply):	
<input type="checkbox"/> City	<input type="checkbox"/> Nonprofit Organization *
<input checked="" type="checkbox"/> County	<input type="checkbox"/> For Profit Organization**
<input type="checkbox"/> Other Political Subdivision	<input type="checkbox"/> HUB Certified
<input type="checkbox"/> State Agency	<input type="checkbox"/> Community-Based Organization
<input type="checkbox"/> Indian Tribe	<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):	
*If incorporated, provide 10-digit charter number assigned by Secretary of State:	
7) PROPOSED BUDGET PERIOD: Start Date: September 1, 2012 End Date: August 31, 2013	
8) COUNTIES SERVED BY PROJECT: Fort Bend County	
9) AMOUNT OF FUNDING REQUESTED: \$258,364.00	11) PROJECT CONTACT PERSON
10) PROJECTED EXPENDITURES Does respondent's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for respondents current fiscal year (excluding amount requested in in line 9 above)?** Yes X No <input type="checkbox"/>	Name: Nancy Drake R.N. Phone: 281-238-3548 Fax: 281-342-7371 Email: drakenan@co.fort-bend.tx.us
**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: 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 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 respondent and I (the person signing below) am authorized to represent the respondent.	
13) AUTHORIZED REPRESENTATIVE Check if change <input type="checkbox"/> Name: Robert Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-6809 Email: hebertb@co.fort-bend.tx.us	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE 
	15) DATE 4-3-2012

FORM B: PROPOSAL TABLE OF CONTENTS AND CHECKLIST

Legal Business Name of

Respondent: Respondent: Fort Bend County Clinical Health Services

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"/>		
B	Proposal 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	Assessment Narrative –included [optional]	<input type="checkbox"/>		<input type="checkbox"/>
G	Performance Measures – included	<input type="checkbox"/>		<input type="checkbox"/>
H	Work Plan – included	<input type="checkbox"/>		
I	Budge Summary Form and Detail Pages	<input type="checkbox"/>		
Exhibit A	FY2013 Work Plan	<input type="checkbox"/>		
Appendix A	DSHS Assurance and Certifications	<input type="checkbox"/>		
Appendix B	Copy of Approved Indirect Rat – included (if applicable)	<input type="checkbox"/>		

FORM C: CONTACT PERSON INFORMATION**PAGE 3****Legal Business Name of Respondent:**

Fort Bend County Clinical Health Services

*This form provides information about the appropriate contacts in the respondent'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:	Nancy Drake R.N.	Mailing Address
Title:	Program Director	Street: 4520 Reading Road, Ste. 200
Phone:	281-238-3548 Ext:	City: Rosenberg
Fax:	281-342-7371	County: Fort Bend County
Email:	drakenan@co.fort-bend.tx.us	State, Zip: 77471
Contact:	Alice Hallgren LVN	Street: 4520 Reading Road, Ste. 200
Title:	Immunization Project Contact	City: Rosenberg
Phone:	281-238-3552 Ext:	County: Fort Bend County
Fax:	281-342-7371	State, Zip: 77471
Email:	hallgali@co.fort-bend.tx.us	
Contact:	Kaye Reynolds, MPH	Street: 4520 Reading Road, Ste. 100
Title:	Project Financial Contact	City: Rosenberg
Phone:	281-238-3519 Ext:	County: Fort Bend County
Fax:	281-342-3355	State, Zip: 77471
Email:	reynokay@co.fort-bend.tx.us	
Contact:	Diane Guest	Street: 4520 Reading Road, Ste. 200
Title:	Project Administrative Assistant	City: Rosenberg
Phone:	281-238-3558 Ext:	County: Fort Bend County
Fax:	281-342-7371	State, Zip: 77471
Email:	guestdia@co.fort-bend.tx.us	
Contact:	Nancy Drake R.N.	Street: 4520 Reading Road, Ste. 200
Title:	Clinical Contact	City: Rosenberg
Phone:	281-238-3548 Ext:	County: Fort Bend County
Fax:	281-342-7371	State, Zip: 77471
Email:	drakenan@co.fort-bend.tx.us	

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 2013.

There have been no changes to the Personnel Classifications listed in last year's application, nor have any of the job descriptions been changed.

Projected amount of the DSHS share of Program Income (from page 30, Budget Summary, Line L, Row 1)
\$

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)	\$0.00	

Forms F-H **PAGE 6**
Forms F-H are not applicable for this contract.

Regional Program Managers FY2013

HEALTH SERVICE REGION 1

Keila Johnson
Immunization Program Manager
300 Victory Drive
Box 60968, WTAMU Station
Canyon, Texas 79016
(806) 655-7151
(806) 655-7159 – Fax

Keila.Johnson@dshs.state.tx.us

HEALTH SERVICE REGION 7

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

Diane.Romnes@dshs.state.tx.us

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.state.tx.us

HEALTH SERVICE REGION 8

Laurie Henefey
Immunization Program Manager
2201 E. Main
Uvalde, Texas 78801
(830) 591-4386 Extension 213
(830) 278-1831 - Fax

Laurie.Henefey@dshs.state.tx.us

HEALTH SERVICE REGIONS 4 & 5 NORTH

Toni Wright
Immunization Program Manager
1517 W. Front Street
Tyler, Texas 75702
(903) 533-5266
(903) 533-9502 - Fax

Toni.Wright@dshs.state.tx.us

HEALTH SERVICE REGIONS 9 & 10

Racheal Porras
Immunization Program Manager
2301 N. Big Spring #300
Midland, Texas 79705-7649
(432) 683-9492
(432) 571-4190 - Fax

Racheal.porras@dshs.state.tx.us

HEALTH SERVICE REGIONS 6 & 5 SOUTH

Kathleen Ingrando, RN, MS
Immunization Program Manager
5425 Polk, Suite J
Houston, Texas 77023
(713) 767-3411
(713) 767-3889 - Fax

Kathleen.ingrando@dshs.state.tx.us

HEALTH SERVICE REGION 11

Ana Ivette Nunez
Immunization Program Manager
601 W. Sesame Drive
Harlingen, Texas 78550
(956) 423-0130
(956) 443-3216 - Fax

Ivette.Nunez@dshs.state.tx.us