InterLocal Application
For
Immunization Program Funds
Fiscal Year 2016

www.ImmunizeTexas.com

Issue date: 04/21/2015
Due date: 05/22/2015

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

Department of State Health Services
FORM A: FACE PAGE

CONTRACTOR INFORMATION			
1) LEGAL BUSINESS NAME: Fort Bend County			
2) MAILING Address Information: Include mailing address, street, city, county, state, and zip code): Fort Bend County, Clinical Health Services 4520 Reading Rd. Ste. A # 200 Rosenberg Texas 77471			Check if address change ☐
3) PAYEE Name and Mailing Address (if different from above: Fort Bend Co. Auditors Office, 301 Jackson St. Richmond Texas 77469			Check if address change ☐
4) DUNS Number (9 digit) required if receiving American Recovery and Reinvestment Act of 2009 (ARRA) funds: N/A			
5) Federal Tax ID no. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) of Social Security Number (9 digit):			
**The contractor acknowledges, understands and agrees that the contractor'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	☐ Nonprofit Organization *	☐ Faith Based (nonprofit Org)	☐ Hospital
X☐ County	☐ For Profit Organization**	☐ Individual	☐ Private
☐ Other Political Subdivision	☐ HUB Certified	☐ Federally Qualified Health Centers	☐ Other (specify):
☐ State Agency	☐ Community-Based Organization	☐ State Controlled Institution of Higher Learning	
☐ Indian Tribe	☐ Minority Organization		
*If incorporated, provide 10-digit charter number assigned by Secretary of State:			
7) PROPOSED BUDGET PERIOD: Start Date: September 1, 2015 End Date: August 31, 2016			
8) COUNTIES SERVED BY PROJECT: Fort Bend County			
9) AMOUNT OF FUNDING REQUESTED: 258,364.00		11) PROJECT CONTACT PERSON	
10)PROJECTED EXPENDITURES Does contractor's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for contractors current fiscal year (excluding amount requested in line 9 above)?** Yes X☐ 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*		Name Alice C. Hallgren LVN Immunization Team Lead Nurse Phone: 281-238-3552 Fax: 281-238-3564 Email: Alice.Hallgren,@fortbendcountyx,gov 12) FINANCIAL OFFICER Name: Ed Sturdivant Phone: 281-341-3760 Fax: 281-341-3774 Email: Robert.Sturdivant@fortbendcountytx.gov	
The facts affirmed by me in this proposal are truthful and I warrant the contractor 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 contractor and I (the person signing below) am authorized to represent the contractor.			
13) AUTHORIZED REPRESENTATIVE Check if change ☐ Name: Robert Hebert Title: Co. Judge Phone: 281-341-8608 Fax: 281-341-8609 Email:Ann.werlein@fortbendcountytx.gov		14) SIGNATURE OF AUTHORIZED REPRESENTATIVE  15) DATE 5/14/2015	

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.***

Contacts must include, but are not limited to: Executive Director, Financial Contact, Program Contact, and Emergency Contact information.

Contact:	Alice C. Hallgren, LVN	Mailing Address	
Title:	Immunization Team Lead Nurse	Street:	4520 Reading Rd. Ste. A #200
Phone:	281-238-3552	City:	Rosenberg
Fax:	281-238-3564	County:	Fort Bend
Email:	Alice.Hallgren@fortbendcountytx.gov	State, Zip:	TX 77471
Contact:	Robert Castaneda	Street:	4520 Reading Rd. Ste. A #200
Title:	IPOS/TVFC	City:	Rosenberg
Phone:	281-238-3590 Ext:	County:	Fort Bend
Fax:	281-238-3564	State, Zip:	TX 77471
Email:	Robert.Castaneda@fortbendcountytx.gov		
Contact:	Kaye Reynolds, DrPH	Street:	4520 Reading Rd. Ste A-100
Title:	Deputy Director /Project Financial Contact	City:	Rosenberg
Phone:	281-238-3519 Ext:	County:	Fort Bend
Fax:	281-342-3355	State, Zip:	TX 77471
Email:	Kaye.Reynolds@fortbendcountytx.gov		
Contact:	Diane Guest	Street:	4520 Reading Rd. Ste. A # 200
Title:	Administrative Assistant	City:	Rosenberg
Phone:	281-238-3558 Ext:	County:	Fort Bend
Fax:	281-342-7371	State, Zip	TX 77471
Email:	Diane.Guest@fortbendcountytx.gov		
Emergency Contact:		Street:	
Title:		City:	
Phone:	Ext:	County:	
Fax:		State, Zip	
Email:			

Form E: PROGRAM INCOME SPENDING PLAN

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	$6,000	Support of the immunization program including direct immunizations and clerical / intake effort
B. Fringe Benefits	$3,000	As above
C. Travel	$700	Local mileage reimbursement for travel to immunization locations
D. Supplies	$1,126	Supplies to support immunization services
E. Contractual	$	
F. Other	$165	Support communication with VFC providers
Total (DSHS Share Program Income)	$10,991	

FORM G: Federal Funding Accountability and Transparency Act (FFATA)
Personnel Activity Detail Form for Local Health Department Immunization Staff

Legal Name of Applicant:	Fort Bend County Clinical Health Services

List Personnel	I. Program Planning & Evaluation	II. Vaccine Management VFC OPS	III. Registries	IV. Provider Quality Assurance VFC AFIX	V. Perinatal Hepatitis B Prevention	VI. Education, Information, Training & Collaborations	VII. Epidemiology and Surveillance	VIII. Population Assessment	IX Service Delivery	Total equals 100%
Functional Title + Code E=Existing or P=Proposed	% Time	% Time	% Time	% Time	% Time	% Time	% Time	% Time	% Time	100% Time
Alice C. Hallgren, LVN Immunization Team Lead	10	10	10	30		10	10	10	10	100%
Lorraine Grieger LVN		10	5		30	5			50	100%
Teresa Dower LVN		10	10			10	20	10	40	100%
Tisha Harper, LVN	10	10		30		20		10	20	100%
Robert Castaneda IPOS/TVFC	5	5	30	30					30	100%
Xavier Villaloboz CSA		10	50						40	100%
Brenda Garcia CSA			20			20			60	100%
Maria Becerra, CSA II			50			10			40	100%
										100%
Beverly Kaack CSA			5			25		10		100%
Diane Guest Admin. Asst.	10								30	100%
Nancy Drake, RN, Director	10					5	5		20	100%
										100%

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 Sources (5)	Other Funds (6)
A. Personnel	$375,502	$150,010	$0	$0	$225,492	$0
B. Fringe Benefits	$192,723	$76,875	$0	$0	$115,848	$0
C. Travel	$18,204	$15,204	$0	$0	$3,000	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$29,700	$12,000	$0	$0	$17,700	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$6,775	$4,275	$0	$0	$2,500	$0
H. Total Direct Costs	$622,904	$258,364	$0	$0	$364,540	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$622,904	$258,364	$0	$0	$364,540	$0
K. Program Income - Projected Earnings	$26,500	$10,991			$15,509	

NOTE: The "Total Budget" amount for each Budget Category will have to be allocated (entered) manually among the funding sources. Enter amounts in whole dollars. 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**	**$375,502**	**$375,502**	**Fringe Benefits**	**$192,723**	**$192,723**
	Travel	**$18,204**	**$18,204**	**Equipment**	**$0**	**$0**
	Supplies	**$29,700**	**$29,700**	**Contractual**	**$0**	**$0**
	Other	**$6,775**	**$6,775**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	Distribution Totals	$622,904	Budget Total	$622,904

*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

Legal Name of Respondent: Fort Bend County Clinical Health Services

PERSONNEL Functional Title + Code 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
Lead Immunization Nurse (1) / E	N	Oversees / Provides Training and QI For / Schedules / Immunization Services	0.4	Yes	$4,391.16	12	$20,814
Immunization Nurses (3) / E	N	Provide Immunization Services	1.19	Yes	$3,444.04	12	$48,974
Community Service Aides (3) / E	N	Support Immunization Services	1.19	No	$2,644.01	12	$37,598
IMMTRAC / PICS / VFC Outreach Specialist (1) / E	N	Provides ImmTrac, Pharmacy and VFC activity support	0.4	No	$3,358.55	12	$15,920
Director of Clinical Health Services (1) / E	N	Directs Immunization Program	0.16	Yes	$6,654.09	12	$12,616
Administrative Assistant (1) / E	N	Purchasing. Payroll, Accounts Payable	0.16	No	$4,571.52	12	$8,668
Community Servie Aide (1) / E	N	Supports Immunization Services	0.16	No	$2,858.45	12	$5,420
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$150,010

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

Fringe Consists of: FICA 7.65%, Pesion 11.79%, WC/Unemployment 3.8%, and Group Health Insurance $11,561 per FTE

Fringe Benefit Rate %	51.25%
Fringe Benefits Total	$76,875

Revised: 7/6/2009

Total for Conference / Workshop Travel $4,152

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Travel to satellite clinics, VFC Provier education and QI visits, ImmTrac/PICS outreach/education/training to providers, school etc, Perinatal Hepatitis B visits.	19220	$0.575	$11,052		$11,052
			$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 $11,052

Other / Local Travel Costs: $11,052 **Conference / Workshop Travel Costs:** $4,152 **Total Travel Costs:** **$15,204**

Indicate Policy Used: **Respondent's Travel Policy** ☐ **State of Texas Travel Policy** ☐

Revised: 7/6/2009

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: Fort Bend County Clinical Health Services

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
Trips to regional health department/Houston, TX	Trips/yr. for two to four employees - program manager, ImmTrac, VFC, and miscelaneous meetings (75 miles round trip x $ .575	Houston, TX	6/4	Mileage	$258
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$258
Trips to Immunization Coalition of Greater Houston (ICOGH) meetings.	4 trips for 1-2 employees to participate in the ICOGH meetings (52 miles round trip x $.575)	Houston, TX	4/2	Mileage	$120
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$120
Trips to the Texas Immunization Stake Holders Work Group meetings	2 trips for 1-2 (1 1/2 days, 1 night, 350 miles round trip x $.575, 2 nights x $120.00, $36 day per diem)	Austin, TX	2/2	Mileage	$201
				Airfare	
				Meals	$108
				Lodging	$480
				Other Costs	
				Total	$789
2 Trips to statewide meeting on Immunization Program	2 trips for workshop/meeting attendance to keep updated on program plans and best practices. (2 trips for 2 1/2 days each x 4 employees). 350 miles x $.575, $36.00 per diem.			Mileage	$201
				Airfare	
				Meals	$864
				Lodging	$1,920
				Other Costs	
				Total	$2,985
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Revised: 7/6/2009

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent: **Fort Bend County Clinical Health Services**

Itemize and describe each supply item and **provide an estimated quantity and cost (i.e. #of boxes & cost/box) if applicable.** Provide a justification for each supply item. Costs may be categorized by each general type (e.g., office, computer, medical, educational, etc.) See attached example for definition of supplies and detailed instructions to complete this form.

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
Office Supplies - paper,toner, and ink cartridges, pens, notepads and miscellaneous items.	Supplies to support immunization printing and copying. Pens, notepads and misc. items for clinic use (3 locations)	$5,000
Medical Supplies - syringes, cotton balls, alcohol and bandaids	To support vaccine delivery	$7,000
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS		$0

Total Amount Requested for Supplies: **$12,000**

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: Fort Bend County Clinical Health Services

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	Purpose & Justification	Total Cost
Cell Phone Service x 2 (12 months @ 65.57)	Cell phone services for ImmTrac/VFC Outreach Specialist and Team Lead Nurse while out in the field	$787
Aircard services (2 laptops @ $45 per month for 12 months)	Communication with TWICES/ImmTrac while conducting audits in the field.	$912
Control Company (8 thermometers to be re-calibrated at $15.00 unit)	Re-calibration of traceable Refrigerator/Freezer Thermometer for vaccine refrigerators to meet VFC requirements	$120
Centigrade Services	Maintenance visits on a semi-annual basis on 2 vaccine refrigerators. ($550 each visit)	$1,100
Stericycle - Monthly $55	Monthly medical waste pick up	$660
Stericycle - Quarterly $15.15	Cost per box of syringes. (10 boxes per quarter)	$606
Stericycle - Quarterly $5.00	Medical waste pick up - Energy charge per pick up	$20
Stericycle - Quarterly $17.50	Medical waste pick up - fuel charge	$70
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$4,275**

Revised: 7/6/2009