



**Inter-Local
Application
For
Tuberculosis Prevention and
Control for FY 2016
State Funds**

<http://www.dshs.state.tx.us/idcu/disease/tb>

TB Services Branch

1100 W. 49th Street
P. O. Box 149347, MS 1990
Austin, Texas 78714



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

KIRK S. COLE
INTERIM COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

June 11, 2015

Fort Bend County Clinical Health Services

RE: Contract Inter-local Application Process for Fiscal Year 2016:

Dear Nancy Drake,

The Texas Department of State Health Services, Tuberculosis (TB) Services Branch, is initiating the contract application process for fiscal year (FY) 2016. This letter is a reminder that the TB Services Branch requires each TB Program to submit a description of your organization, resources and capacity; and a detailed budget justification. This must be completed before any contract can be issued to your agency. This year's contracts will contain sixteen (16) performance measures that will be the same for all local health departments. Please review carefully the section of the application pertaining to performance measures. **We are currently providing a one-year allocation; however, it is the intent for the TB/State contract to be amended at a later date to extend to two years.**

The TB/State ILA is also being distributed at this time, along with the FY2016 budget allocation of 134,397. Contractor shall provide a match of no less than 20% of the DSHS share of the total budget which is \$26,879. The due date for submission of the ILA's and Budget to DSHS is June 29, 2015. Please submit via email to Kathy Sharp at the email address noted below. The contract expenditures will be closely scrutinized and expenses not considered absolutely essential for delivery of direct client services may be eliminated or reduced.

In the event that the Texas Department of State Health Services (DSHS) is informed of state increases or decreases to funding amounts, or other unforeseen internal budgetary shortfalls, DSHS may find it necessary to amend funding allocations to its contractors.

If you have any questions or need additional information, please contact Kathy Sharp, Contract Manager, Disease Control and Prevention Services, Contract Management Unit at (512) 776-2640 or by e-mail at kathy.sharp@dshs.state.tx.us

Sincerely,

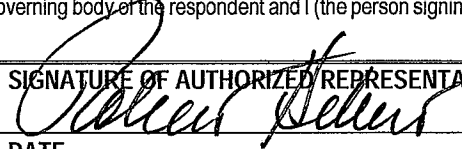
Kathy Sharp, Contract Manager
Division for Disease Control and Prevention Services
Contract Management Unit

Attachment

cc: Sandra A. Morris, M.P.H., Manager, Tuberculosis and Refugee Health Services Branch
Peggy Wittie, PhD, MAG, Manager, Tuberculosis and Hansen's Disease Group
Cynthia Lewis, Program Specialist, Tuberculosis and Refugee Health Services Branch

**Department of State Health Services
Form A Face Page – Tuberculosis (TB) Funding**

RESPONDENT INFORMATION

1) LEGAL BUSINESS NAME: Fort Bend County Clinical Health Services																			
2) MAILING Address Information (include mailing address, street, city, county, state and 9-digit zip code): Check if address change <input type="checkbox"/> 4520 Reading Road, Suite A-100 Rosenberg Texas 77471																			
3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above): Check if address change <input type="checkbox"/> Fort Bend County Auditor - 301 Jackson Street, Suite 701- Richmond Texas 77469																			
4) DUNS Number (9-digit) required if receiving federal funds:																			
5) Federal Tax ID No. (9-digit), State of Texas Comptroller Vendor ID Number (14-digit) or 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): <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"/> Federally Qualified Health Centers</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> <p><i>*If incorporated, provide 10-digit charter number assigned by Secretary of State:</i> _____</p>		<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"/> Federally Qualified Health Centers	<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): _____
<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"/> Federally Qualified Health Centers																	
<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): _____																	
7) PROPOSED BUDGET PERIOD: Start Date: 09/01/2015 End Date: 08/31/2016																			
8) COUNTIES SERVED BY PROJECT: Fort Bend County																			
9) AMOUNT OF FUNDING REQUESTED: \$ 134,397.00	11) PROJECT CONTACT PERSON Name: Kaye Reynolds, DrPH Phone: 281-238-3519 Fax: 281-342-7371 Email: Kaye.Reynolds@fortbendcountytexas.gov																		
10) PROJECTED EXPENDITURES Does respondent's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for respondent's <u>current fiscal year</u> (excluding amount requested in line 9 above)? ** Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <i>**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.</i>	12) FINANCIAL OFFICER Name: Ed Sturdivant Phone: 281-341-3760 Fax: 281-341-3374 Email: Ed.Sturdivant@fortbendcountytexas.gov																		
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 B: 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.																			
13) AUTHORIZED REPRESENTATIVE Check if change <input type="checkbox"/> Name: Robert Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-6809 Email: 281-341-6809	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE  15) DATE June 23, 2015																		