TEXAS Department

Department of State Health Services

CONTRACTOR INFORMATION

1) LEGAL BUSINESS NAME: Fort Bend County

2) MAILING Address Information (include mailing address, street, city, county, state and 9-digit zip code): **Check if address change** ☐

4520 Reading Road, Suite A-200 Rosenberg, Texas 77471

3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above): **Check if address change** ☐

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

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.

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

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

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

7) PROPOSED BUDGET PERIOD: **Start Date:** ***09/01/2017*** **End Date:** ***08/31/2019***

8) COUNTIES SERVED BY PROJECT:

Fort Bend County

9) AMOUNT OF FUNDING REQUESTED: 292,639.00

10) PROJECTED EXPENDITURES

Does respondent's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for respondent's current fiscal year (excluding amount requested in line 9 above)? **

Yes ☐ 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.*

11) PROJECT CONTACT PERSON

Name: Kaye Reynolds, DrPh
Phone: 281-238-3519
Fax: 281-342-7371
Email: Kaye.Reynolds@fortbendcountytx.gov

12) FINANCIAL OFFICER

Name: Ed Sturdivant
Phone: 281-341-3790
Fax: 281-3374
Email: Ed.Sturdivant@fortbendcountytx.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 **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** ☐

Name: Robert Hebert
Title: County Judge
Phone: 281-341-8608
Fax: 281-341-6809
Email: Robert.Hebert@fortbendcountytx.gov

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

15) DATE

1-24-2017

CONTACT PERSON INFORMATION

Legal Business Name of Contractor FORT BEND COUNTY

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.*** ***Please provide at least one (1) Emergency Contact as noted below.***

Emergency Contact:	Kaye Reynolds, DrPh		**Mailing Address (incl. street, city, county, state, & zip):**
Title:	Deputy Director		4520 Reading Road, Suite A-100
Phone:	281-238-3519	Ext.	Rosenberg, Texas 77471
Fax:	281-342-7371		
Email:	Kaye.Reynolds@fortbendcountytx.gov		
Contact:	Ngombe Bitendelo, RN,MPH		**Mailing Address (incl. street, city, county, state, & zip):**
Title:	CHS Director		4520 Reading Road, Suite A-200
Phone:	281-238-3548	Ext.	Rosenberg, Texas 77471
Fax:	281-342-7371		
Email:	Ngombe.Bitendelo@fortbendcountytx.gov		
Contact:	Catalina Lozano		**Mailing Address (incl. street, city, county, state, & zip):**
Title:	Epidemiologist		4520 Reading Road, Suite A-200
Phone:	281-238-3579	Ext.	Rosenberg, Texas 77471
Fax:	281-342-7371		
Email:	Catalina.Lozano@fortbendcountytx.gov		
Contact:			**Mailing Address (incl. street, city, county, state, & zip):**
Title:			
Phone:		Ext.	
Fax:			
Email:			
Contact:			**Mailing Address (incl. street, city, county, state, & zip):**
Title:			
Phone:		Ext.	
Fax:			
Email:			

INSTRUCTIONS

This form provides basic information about the Contractor and the proposed project with the Department of State Health Services (DSHS), including the signature of the authorized representative. Please follow the instructions below to complete the form and return to the Contractor Management Unit.

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 9-digit 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, including 9-digit zip code, 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. . This number is required if receiving **ANY** federal funds and can be obtained at: **http://fedgov.dnb.com/webform**

5) **FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Texas 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 its 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 and/or the Texas State Comptroller at https://fmx.cpa.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 contract.

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.

CONTACT PERSON INFORMATION INSTRUCTIONS

Please provide at least one (1) Emergency Contact.

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: Fort Bend County

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	$198,745	$198,745	$0	$0	$0	$0
B. Fringe Benefits	$87,786	$87,786	$0	$0	$0	$0
C. Travel	$2,428	$2,428	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$0	$0	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$3,680	$3,680	$0	$0	$0	$0
H. Total Direct Costs	$292,639	$292,639	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$292,639	$292,639	$0	$0	$0	$0
K. Program Income - Projected Earnings	$0	$0				

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**	**$198,745**	**$198,745**	**Fringe Benefits**	**$87,786**	**$87,786**
	Travel	**$2,428**	**$2,428**	**Equipment**	**$0**	**$0**
	Supplies	**$0**	**$0**	**Contractual**	**$0**	**$0**
	Other	**$3,680**	**$3,680**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	Distribution Totals	$292,639	Budget Total	$292,639

*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

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
Epidemiologist	N	This position will work with local and state health department to improve the investigation and reporting of all outbreaks.	1	N/A	$4,713.00	24	$113,112
Epidemiologist	N	This position will work with local and state health department to improve the investigation and reporting of all outbreaks.	1	N/A	$4,507.00	19	$85,633
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$198,745

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

Payroll Taxes 7.65% - Retirement 11.95% - Worker Comp 3.8%, Insurance 11,561.00

Fringe Benefit Rate %	44.17%
Fringe Benefits Total	$87,786

Revised: 7/6/2009

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: Fort Bend County

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
ELC Workshop For 2018	Mandatory Training For Contracted Epidemiologist	Austin	4/2	Mileage	
				Airfare	
				Meals	$252
				Lodging	$720
				Other Costs	
				Total	$972
ELC Workshop For 2019	Mandatory Training For Contracted Epidemiologist	Austin	4/2	Mileage	
				Airfare	
				Meals	$252
				Lodging	$720
				Other Costs	
				Total	$972
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $1,944

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Travel to hospitals, doctor's offices and potentially patient homes for data gathering and specimen collection.	904	0.535	$484		$484
			$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 $484

Other / Local Travel Costs: $484 **Conference / Workshop Travel Costs:** $1,944 **Total Travel Costs:** $2,428

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

Revised: 7/6/2009

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: **Fort Bend County**

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	**Purpose & Justification**	**Total Cost**
Cell Phone Charge- Monthly Charge $75.00 / 2 Employees / 48 months	Communication with local department, hospitals, doctors, patients and DSHS	$3,600
IPAD AIR Monthly Charge Fee for Two Years	Commnicate and educate hospitals, doctors, patients and healthcare employees during an outbreak	$80
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$3,680**