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

RESPONDENT 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 ☐
Fort Bend County – 301 Jackson Street, Richmond, Texas 77469

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: 01/01/2018 End Date: 12/31/2018

8) COUNTIES SERVED BY PROJECT:
Fort Bend County

9) AMOUNT OF FUNDING REQUESTED: 99,186.00

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: 281-341-3760
Fax: 281-341-3374
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 **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
Signature: Robert Hebert Check if change ☐ 5/15/2017
Name: Robert Hebert
Title: County Judge
Phone: 281-341-8608
Fax: 281-341-8609
Email: county.judge@fortbendcountytx.gov

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

RESPONDENT 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** ☐

Fort Bend County – 301 Jackson Street, Richmond, Texas 77469

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

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

7) PROPOSED BUDGET PERIOD: **Start Date:** 01/01/2018 **End Date:** 12/31/2018

8) COUNTIES SERVED BY PROJECT:

Fort Bend County

9) AMOUNT OF FUNDING REQUESTED: 99,186.00

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:
Email: 281-342-7371
Kaye.Reynolds@fortbendcountytx.gov

12) FINANCIAL OFFICER

Name: Ed Sturdivant
Phone: 281-341-3760
Fax:
Email: 281-341-3374
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 **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

Signature: Robert Hebert **Check if change** ☐ 12/15/2017

Name: Robert Hebert
Title: County Judge
Phone: 281-341-8608
Fax:
Email: 281-341-8609
county.judge@fortbendcountytx.gov

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 (Match) (5)	Other Funds (6)
A. Personnel	$46,080	$46,080			$0	
B. Fringe Benefits	$22,422	$22,422			$0	
C. Travel	$6,003	$6,003			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$0	$0			$0	
F. Contractual	$24,681	$24,681			$19,837	
G. Other	$0	$0			$0	
H. Total Direct Costs	$99,186	$99,186	$0	$0	$19,837	$0
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$99,186	$99,186	$0	$0	$19,837	$0
K. Program Income - Projected Earnings	$0	$0	$0	$0	$0	$0

NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts in whole dollars for (3), (4), & (6), *If applicable*. 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	$46,080	$46,080	Fringe Benefits	$22,422	$22,422
	Travel	$6,003	$6,003	Equipment	$0	$0
	Supplies	$0	$0	Contractual	$44,518	$24,681
	Other	$0	$0	Indirect Costs	$0	$0

TOTAL FOR:	Distribution Totals	$119,023	Budget Total	$99,186

*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 Name + Functional Title 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
Delores Ollie LPN, DOT/CI, E	N	Provide DOT/DOPT to TB patients,contacts,suspects. Initiates and completes contact investigations related to cases and suspects in the county and those referred by outside agencies.	1	LPN	$3,840.00	12	$46,080
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$46,080

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

Fringe Benefits include FICA 7.65%, Pension 12.12%, W/C 3.8%, Health Insurance $11,561 per FTE

Fringe Benefit Rate %	48.65%
Fringe Benefits Total	$22,422

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
DOT/DOPT TB suspects,cases, TBII's on 3HP and TBII's at high risk of failure to complete treatment. Contact Investigation of suspects and cases in Ft. Bend Co. Travel to local meetings	11221	$0.535	$0		$6,003
			$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 $6,003

Other / Local Travel Costs: $6,003 **Conference / Workshop Travel Costs:** $0 **Total Travel Costs:** $6,003

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

Revised: 1/27/2012

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent: FORT BEND COUNTY

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order/quote.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
	TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS			$0

Total Amount Requested for Equipment: $0

Revised: 1/27/2012

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent: FORT BEND COUNTY

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**
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$0**

Revised: 1/27/2012

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: FORT BEND COUNTY

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors a
Justification for any contract that delegates $100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly rate, unit rate, lump sum amount)
Oak Bend Medical Center	Chest x-rays	Diagnosis/Management of TB patients	Unit	150	$45
West Houston Radiology	Reading of Chest x-rays	Diagnosis/Management of TB patients	Unit	150	$15
Oak Bend Medical Center	Ct Scans of Chest	Diagnosis/Management of TB patients	Unit	1	$406
West Houston Radiology	Reading of CT scans	Diagnosis/Management of TB patients	Unit	1	$100
Various	DOT providers	Assist with delivery of TB medication to patients via DOT	Unit	607	$25
				TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	

Total Amount Requested for CONTRACTUAL:

as "To Be Named."

TOTAL
$6,750
$2,250
$406
$100
$15,175
$0
$0
$0
$24,681
$24,681

Revised: 1/27/2012

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
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$0**

Page 2, FORM I - 7 Indirect Costs

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**

FORM I - 7 Indirect Costs

Legal Name of Respondent: FORT BEND COUNTY

Total amount of indirect costs allocable to the project: **Amount:** $0

Indirect costs are based on (mark the statement that is applicable):

The respondent's most recent indirect cost rate approved by a federal cognizant agency or state single audit coordinating agency. **Expired rate agreements are not acceptable. Attach a copy of the rate agreement to this form (Form I - 7 Indirect)**

RATE:
BASE:

Applies only to governmental entities. The respondent's current central service cost rate or indirect cost rate based on a rate proposal prepared in accordance with OMB Circular A-87. **Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.**

RATE:
TYPE:
BASE:

Note: Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date. The CFPM is available on the following internet web link: http://www.dshs.state.tx.us/contracts/

GO TO PAGE 2 (below)

SUPPLEMENTAL and MATCH FORMS INSTRUCTIONS

The budget templates include a SUPPLEMENTAL and a MATCH page (one per budget category) that follow are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template. The MATCH pages (one per budget category) are intended to record the required match will be utilized to list detail information for the required match.
The amounts on each supplemental template will automatically populate from the templates and will be inserted on the last line of the primary budget template.
The amounts on each match template will automatically populate from the templates and will be inserted in column labeled "Local Funding Sources (5)"

The SUPPLEMENTAL and MATCH budget templates are:

Form I-1a Personnel Supplemental
Form I-2a Travel Supplemental
Form I-3a Equipment Supplemental
Form I-4a Supplies Supplemental
Form I-5a Contractual Supplemental
Form I-6a Other Supplemental

Form I-1b Personnel Match
Form I-2b Travel Match
Form I-3b Equipment Match
Form I-4b Supplies Match
Form I-5b Contractual Match
Form I-6ba Other Match