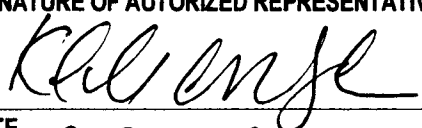


**FORM A: FACE PAGE**

*Proposal for Financial Assistance*

*This form requests basic information about the contractor and project, including contact information for the person authorized to sign the contract.*

<b>CONTRACTOR INFORMATION</b>																			
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): <span style="float: right;">Check if address change <input type="checkbox"/></span> 4520 Reading Road, Suite A-200 Rosenberg, Texas 77471																			
3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above): <span style="float: right;">Check if address change <input type="checkbox"/></span> 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 746001969																			
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>		<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: 09/01/2019 End Date: 08/31/2021																			
8) COUNTIES SERVED BY PROJECT: Fort Bend County																			
9) AMOUNT OF FUNDING REQUESTED: 319,019	11) PROJECT CONTACT PERSON  Name: Kaye Reynolds, DrPH Phone: 281-238-3519 Fax: 832-471-1808 Email: Kaye.Reynolds@fortbendcountytx.gov																		
10) PROJECTED EXPENDITURES Does the contractor's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for contractor's current fiscal year (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: 281-341-3790 Fax: 281-341-3374 Email: Ed.Sturdivant@fortbendcountytx.gov																		
13) PERSON AUTHORIZED TO SIGN CONTRACT <span style="float: right;">Check if change <input type="checkbox"/></span>	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE																		
Name: KP George Title: County Judge Phone: 281-341-8608 Fax: 281-341-6809 Email: Kp.George@fortbendcountytx.gov																			
	15) DATE 2.12.2019  01/30/2019																		

## FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the contractor and the proposed project with the Department of State Health Services (DSHS). Please follow the instructions below to complete the face page form and return with the contractor's budget.

- 1) **LEGAL BUSINESS NAME** - Enter the legal name of the contractor.
- 2) **MAILING ADDRESS INFORMATION** - Enter the contractor'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 contractor to receive payment for services rendered by contractor 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 contractor. 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).
- 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://fm.x.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS\\_Guide\\_0409.pdf](https://fm.x.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 proposal.
- 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 contractor's projected federal expenditures exceed \$500,000 or its projected state expenditures exceed \$500,000 for contractor's current fiscal year, contractor 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) **PERSON AUTHORIZED TO SIGN CONTRACT** - Enter the name, title, phone, fax, and email address of the person authorized to sign the contract. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

## 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	\$216,960	\$216,960	\$0	\$0	\$0	\$0
B. Fringe Benefits	\$95,831	\$95,831	\$0	\$0	\$0	\$0
C. Travel	\$6,228	\$6,228	\$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	\$0	\$0	\$0	\$0	\$0	\$0
H. Total Direct Costs	\$319,019	\$319,019	\$0	\$0	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$319,019	\$319,019	\$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 Category	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
<b>Check Totals For:</b>	Personnel	\$216,960	\$216,960	Fringe Benefits	\$95,831	\$95,831
	Travel	\$6,228	\$6,228	Equipment	\$0	\$0
	Supplies	\$0	\$0	Contractual	\$0	\$0
	Other	\$0	\$0	Indirect Costs	\$0	\$0

<b>TOTAL FOR:</b>	<b>Distribution Totals</b>	<b>\$319,019</b>	<b>Budget Total</b>	<b>\$319,019</b>
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\*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.

	<b>Fringe Benefits Total</b>	<b>\$95,831</b>
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## FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent:

Fort Bend County

<b>PERSONNEL</b>	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
Functional Title + Code E = Existing or P = Proposed							
Epidemiologist	N	This position will work with local and state health department to improve the investigation and reporting of all outbreaks.	1	N/A	\$4,520.00	24	\$108,480
Epidemiologist	N	This position will work with local and state health department to improve the investigation and reporting of all outbreaks.	1	N/A	\$4,520.00	24	\$108,480
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
<b>TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS</b>							<b>\$0</b>
						<b>SalaryWage Total</b>	<b>\$216,960</b>

<b>FRINGE BENEFITS</b>	Itemize the elements of fringe benefits in the space below:
Payroll Taxes 7.65% - Retirement 12.12% - Worker Comp 1%, Property and Casualty 2.8%, Insurance 10,200	
<b>Fringe Benefit Rate %</b>	
<b>44.17%</b>	

## 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:		Travel Costs
			Days/Employees		
Epi Workshop Austin	ELC Required Epi Training - 2 nights for 2019- @ 164.00 per night - 2 nights for 2020 @164.00 per night - Hotel Rate based on GSA RATES	Austin	4/2	Mileage	
				Airfare	
				Meals	
				Lodging	\$656
				Other Costs	
				<b>Total</b>	<b>\$656</b>
DIN Conference	James Steele Conference Diseases in Nature Transmissible in To Man 2020 & 2021 - Hotel based on highest state rate	?	8/2	Mileage	
				Airfare	\$1,600
				Meals	
				Lodging	\$1,312
				Other Costs	
				<b>Total</b>	<b>\$2,912</b>
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	<b>\$0</b>
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				<b>Total</b>	<b>\$0</b>
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					<b>\$0</b>

Total for Conference / Workshop Travel

**\$3,568**

**Other / Local Travel Costs**

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Visit providers, hospitals, nursing home etc., to educate regarding reporting communicable disease to Public Health Department.	4586	\$0.580	\$2,660		\$2,660
			\$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 **\$2,660**

Other / Local Travel Costs: **\$2,660**

Conference / Workshop Travel Costs: **\$3,568**

Total Travel Costs: **\$6,228**

Indicate Policy Used:

Respondent's Travel Policy

State of Texas Travel Policy





## 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 as "To Be Named." 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)	TOTAL
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL:

\$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)

## FORM I-1: PERSONNEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County

<b>PERSONNEL</b>	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
Functional Title + Code E = Existing or P = Proposed							
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
<b>SalaryWage Total</b>							<b>\$0</b>

**FORM I-1: PERSONNEL Budget Category Detail Form (Supplemental)**

Legal Name of Respondent:

Fort Bend County

<b>PERSONNEL</b>							
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
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
						<b>SalaryWage Total</b>	<b>\$0</b>

## SUPPLEMENTAL FORMS INSTRUCTIONS

The budget templates (two 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. Applicants that have utilized all the lines on the primary budget template must use the supplemental templates to list detail information for the respective budget category. For example, after all the lines on the primary budget template for Personnel (tab labeled Form I - 1 Personnel) have been used, go to the supplemental template labeled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labeled "Form I - 1b Personnel". The amounts on each supplemental template will automatically total and the total from both templates will automatically be inserted on the last line of the primary budget template.

The supplemental budget templates are:

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