CONTACT PERSON INFORMATION

Legal Business Name: Fort Bend County

This form provides information about the appropriate contacts in the contractor's organization. If any of the following information changes during the term of the contract, please send written/e-mail notification to the Assigned Contract Manager.

Health Director / CEO / Executive Di Jacquelyn Johnson Minter
Direct Phone: 281-342-6414 Ext:
E-mail: Barbarah.Martinez@fortbendcountytx.gov

Mailing Address (street, city, county, & zip):
4520 Reading Road, Suite A-200
Rosenberg, Texas 77471

B-13 Submitter: Humera Ansari
Direct Phone: 281-344-3978 Ext:
E-mail: Humera.Ansari@fortbendcountytx.gov

Mailing Address (street, city, county, & zip):
301 Jackson Street, Suite 701
Richmond, Texas 77469

Program Lead Person: Alma Rangel, RN
Direct Phone: 281-238-3548 Ext:
E-mail: Alma.Rangel@fortbendcountytx.gov

Mailing Address (street, city, county, & zip):
4520 Reading Road, Suite A-200
Rosenberg, Texas 77471

Contract Lead Person: Barbarah Martinez MSN, APRN, FNP-BC
Direct Phone: 281-238-3548 Ext:
E-mail: Barbarah.Martinez@fortbendcountytx.gov

Mailing Address (street, city, county, & zip):
4520 Reading Road, Suite A-200
Rosenberg, Texas 77471

Contract Authorized Signatory: KP George
Direct Phone: 281-341-8608 Ext:
E-mail: County.Judge@fortbendcountytx.gov

Mailing Address (street, city, county, & zip):
301 Jackson Street, Suite 701
Richmond, Texas 77469

Additional Contract Authorized Sign
Direct Phone: Ext:
E-mail:

Mailing Address (street, city, county, & zip):

FFATA/Assurances Signatory: KP George
Direct Phone 281-341-8608 Ext:

Mailing Address (street, city, county, & zip):

FY23- TB STATE

Applicant Information

Legal Name of Applicant Agency:	Fort Bend County
Mailing Address:	
Street / PO Box:	301 Jackson Street
City:	Richmond
Zip:	77469
Payee Name:	Fort Bend County Auditor
Payee Mailing Address:	
Street / PO Box:	301 Jackson Street
City:	Richmond
Zip:	77469
State of Texas Comptroller Vendor ID # (11 digit + 3 digit mail code)**:**	746001969
DUNS # (9 digits required for subrecipient contractors)**:**	81497075
Fiscal Year-End Date (MM/DD)	2023-08/31

Type of Entity (Choose one)

City:	☐ Click on appropriate box
County:	☑
Other Political Subdivision:	☐
Nonprofit Organization	☐
Community-Based Organization	☐
Hospital	☐
State Controlled Institution of Higher Learning	☐
Other	☐
Faith Based (Nonprofit Org)	☐

Contract Term:

Start Date:	9/1/2022
End Date:	8/31/2023

State-wide or Counties Served

State-wide or County(ies) Served:	Fort Bend County
Amount of Funding Allocated:	$184,037.00

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	$148,068	$111,261			$36,807	
B. Fringe Benefits	$67,951	$67,951			$0	
C. Travel	$0	$0			$0	
D. Equipment	$0	$0			$0	
E. Supplies	$9	$9			$0	
F. Contractual	$4,816	$4,816			$0	
G. Other	$0	$0			$0	
H. Total Direct Costs	$220,844	$184,037	$0	$0	$36,807	$0
I. Indirect Costs	$0	$0				
J. Total (Sum of H and I)	$220,844	$184,037	$0	$0	$36,807	$0
				Match Percentage	**20.00%**	

Revised: 04/14/2014

PERSONNEL Budget Category Detail Form

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

PERSONNEL Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)	Estimated Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
Latasha Morris	N	Contact investigation workflow. Collection of blood such as IGRA, HIV, Hep B, Hep C, CMP and CBC. Assists with ITEAMS inventory to ensure medication reconcilliation is completed and accurate.	1.00	LVN	$4,035	12	$48,420
Sandra Pileggi	N	Contact investigation workflow. Collection of blood such as IGRA, HIV, Hep B, Hep C, CMP and CBC. Assist with data entry into THISIS of contacts	0.50	LVN	$5,080	12	$30,480
Lorena Ortega	N	TB data entry: TB cases, those suspected of having TB and LTBI date entry to meet all DSHS guidelines of data entry. Intake of initial referral, upload to EHR and task for followup.	1.00	N/A	$2,697	12	$32,361
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					TOTAL FROM PERSONNEL SUPPLEMENTAL SHEETS		$0
						SalaryWage Total	$111,261

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

Payroll Taxes 7.65%, Retirement 13.45%, WC/Unemployment/Property/Casualty Liability 2.8%, Health insurance $16,100.

Total Number of FTEs:	**2.50**		Fringe Benefit Rate %	61.07%
			Fringe Benefits Total	$67,951

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	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $0

Revised: 3/25/2014

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$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 $0

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

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

Revised: 3/25/2014

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 Cost
				$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: 3/25/2014

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.)

Description of Item Provide estimated quantity and cost	Purpose & Justification	Total Cost
Medical supplies	Day to day operations. Venipuncture needles, vacutainers, alcohol wipes, gauze, bandaids, and tourniquets. Personal protective equipment, such as gloves and N-95 masks.	$9
Office supplies	Pens, sharpies, paper.	$0
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$9**

Revised: 3/25/2014

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., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Payments	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL COST
Executeam	Directly observed therapy	Agency staff providing directly observed therapy to enusre TB patients complete regimen.	unit	112	$43.00	$4,816
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
				TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS		$0

Total Amount Requested for CONTRACTUAL: $4,816

Revised: 3/25/2014

OTHER COSTS Budget Category Detail Form

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

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 3/25/2014

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 (Indirect Costs)**	**RATE:**	**EXAMPLE** 8.75%
	BASE:	**EXAMPLE** - Modified total direct, including subgrants and subcontracts up to the first $25,000; excluding equipment, capital equipment, as well as the portion of each subgrant and subcontract in excess of $25,000.00.

***INSTRUCTIONS**: Organizations that have an approved indirect cost rate should complete the section above by marking the box and indicating the rate and base. A copy of the approved rate agreement that will be in effect during the contract term should be submitted with the Budget Templates. If a rate agreement is pending, submit the latest approved agreement.*

I attest that I have not had an approved indirect cost rate and I am requesting/electing to utilize the de minimis indirect cost rate.

I elect not to request indirect costs.

SUPPLEMENTAL and MATCH FORMS INSTRUCTIONS

The budget templates include a SUPPLEMENTAL and a MATCH page (one per budget category) that 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:

Personnel Supplemental
Travel Supplemental
Equipment & Controlled Assets Supplemental
Supplies Supplemental
Contractual Supplemental
Other Costs Supplemental

Personnel Match
Travel Match
Equipment & Controlled Assets Match
Supplies Match
Contractual Match
Other Costs Match

PERSONNEL Budget Category Detail Form (Supplemental)

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

PERSONNEL Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)	Estimated Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
			0.00				
					SalaryWage Total		$0

PERSONNEL Budget Category Detail Form (Match)

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

PERSONNEL Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)	Estimated Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
Alma Rangel RN TB Program Manager	N	TB surveillance	0.40	RN	$7,753	12	$36,807
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$36,807

FRINGE BENEFITS	**Itemize the elements of fringe benefits in the space below:**	
	Fringe Benefit Rate %	
	Fringe Benefits Total	$0

TRAVEL Budget Category Detail Form (Supplemental)

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	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0

Total for Conference / Workshop Travel $0

Revised: 3/25/2014

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0

Total for Other / Local Travel $0

Other / Local Travel Costs: $0

Conference / Workshop Travel Costs: $0

Total Travel Costs: $0

TRAVEL Budget Category Detail Form (Match)

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	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0

Total for Conference / Workshop Travel $0

Revised: 3/25/2014

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0

Total for Other / Local Travel $0

Other / Local Travel Costs: $0

Conference / Workshop Travel Costs: $0

Total Travel Costs: $0

Revised: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category
Detail Form (Supplemental)

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

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

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 Amount Requested for Equipment: **$0**

Revised: 3/25/2014

EQUIPMENT AND CONTROLLED ASSETS Budget Category
Detail Form (Match)

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

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

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
				$0

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

Revised: 3/25/2014

SUPPLIES Budget Category Detail Form (Supplemental)

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 (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost

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

SUPPLIES Budget Category Detail Form (Match)

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 (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost

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

Revised: 3/25/2014

CONTRACTUAL Budget Category Detail Form (Supplemental)

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 de

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0

Total Amount Requested for CONTRACTUAL: $0

CONTRACTUAL Budget Category Detail Form (Match)

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 de

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0

Total Amount Requested for CONTRACTUAL: $0

OTHER COSTS Budget Category Detail Form (Supplemental)

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

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

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

Revised: 3/25/2014

OTHER COSTS Budget Category Detail Form (Match)

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

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

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

Revised: 3/25/2014