



**Inter-Local
Application
For
Tuberculosis Prevention and
Control for FY 2010
State Funds**

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

Issue date:

Due date:

Infectious Disease Intervention and Control Branch

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

David L. Lakey, M.D.
Commissioner

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Department of State Health Services (DSHS)
FORM A: FACE PAGE – Inter-Local
Application for Financial Assistance

This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the application and shall be completed in its entirety.

APPLICANT INFORMATION	
1) LEGAL NAME:	Collin County Health Care Services
2) MAILING Address Information (include mailing address, street, city, county, state and zip code):	Check if address change <input type="checkbox"/>
Collin County Health Care 825 N. McDonald Street, Ste 130 McKinney, Tx 75069	
3) PAYEE Mailing Address (if different from above):	Check if address change <input checked="" type="checkbox"/>
Collin County Auditor's Office 2300 Bloomdale Road, Suite 3100, McKinney, Texas 75071	
4) Federal Tax ID No. (9 digit) or State of Texas Comptroller Vendor ID No. (14 digit)	75-6000873
5) TYPE OF ENTITY (check all that apply):	
<input type="checkbox"/> City	<input checked="" type="checkbox"/> Nonprofit Organization*
<input checked="" type="checkbox"/> County	<input type="checkbox"/> For Profit Organization*
<input type="checkbox"/> Other Political Subdivision	<input type="checkbox"/> HUB Certified
<input type="checkbox"/> State Agency	<input type="checkbox"/> Community-Based Organization
<input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Minority Organization
	<input type="checkbox"/> Individual
	<input type="checkbox"/> FQHC
	<input type="checkbox"/> State Controlled Institution of Higher Learning
	<input type="checkbox"/> Hospital
	<input type="checkbox"/> Private
	<input type="checkbox"/> Other (specify): _____
<i>*If incorporated, provide 10-digit charter number assigned by Secretary of State:</i>	
6) HUB REQUIREMENTS:	
Are you a governmental body bound by HUB or MWBE (Minority & Women's Business Enterprise) mandates/requirements? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", no further action is required. If "No", contact the DSHS HUB Coordinator at 1-800-243-7487 or by e-mail at HUB-Contact@dshs.state.tx.us .	
7) PROPOSED BUDGET PERIOD:	Start Date: 09/01/2009 End Date: 08/31/2010
8) COUNTIES SERVED BY PROJECT:	Collin
9) AMOUNT OF FUNDING REQUESTED: \$	\$158,230
10) PROJECTED EXPENDITURES	11) PROJECT CONTACT PERSON
Does applicant's projected state or federal expenditures exceed \$500,000 for applicant's current fiscal year (excluding amount requested in line 8 above)? **	Name: Patsy Morris Phone: 972-548-5503 Fax: 972-548-5550 E-mail: pmorris@co.collin.tx.us
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	12) FINANCIAL OFFICER
<i>**Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.</i>	Name: Don Cozad Phone: 972-548-4641 Fax: 972-548-4696 E-mail: pmorris@co.collin.tx.us
The facts affirmed by me in this Application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in APPENDIX A: DSHS Assurances and Certifications . I understand that 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 applicant and I (the person signing below) am authorized to represent the applicant.	
13) AUTHORIZED REPRESENTATIVE Check if change <input type="checkbox"/>	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE
Name: Keith Self Title: County Judge Phone: 972-548-4635	
	15) DATE 7/13/09

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FORM B: Inter-Local APPLICATION CHECKLIST

Legal Name of applicant: Collin County Health Care Services

This form is provided to ensure that the application is complete, proper signatures are included, and the required assurances, certifications, and attachments have been submitted.

FORM	DESCRIPTION	Included
A	Face Page completed, and proper signatures and date included	X
B	Application Checklist completed and included	X
C	Contact Person Information completed and included	X
D	Administrative Information completed and included (with supplemental documentation attached if required)	X
E	Organization, Resources and Capacity included	X
F	Performance Measures included	X
G	Work Plan included	X

FORM C: CONTACT PERSON INFORMATION

Legal Name of Applicant: Collin County Health Care Services

This form provides information about appropriate contacts in the applicant'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 Infectious Disease Intervention and Control Branch.

<p>Contact <u>Candy Blair</u></p> <p>Title: <u>Administrator</u></p> <p>Phone: <u>(972) 548-5504</u> Ext. _____</p> <p>Fax: <u>(972) 548-5550</u></p> <p>E-mail: <u>cblair@co.collin.tx.us</u></p>	<p>Mailing Address (incl. street, city, county, state, & zip):</p> <p><u>825 N. McDonald Street, Ste. 130</u></p> <p><u>McKinney</u></p> <p><u>Collin County</u></p> <p><u>Texas 75069</u></p>
<p>Contact <u>Patsy Morris</u></p> <p>Title: <u>HC Coordinator</u></p> <p>Phone: <u>(972) 548-5503</u> Ext. _____</p> <p>Fax: <u>(972) 548-5550</u></p> <p>E-mail: <u>pmorris@co.collin.tx.us</u></p>	<p>Mailing Address (incl. street, city, county, state, & zip):</p> <p><u>825 N. McDonald Street, Ste. 130</u></p> <p><u>McKinney</u></p> <p><u>Collin County</u></p> <p><u>Texas 75069</u></p>
<p>Contact _____</p> <p>Title: _____</p> <p>Phone: _____ Ext. _____</p> <p>Fax: _____</p> <p>E-mail: _____</p>	<p>Mailing Address (incl. street, city, county, state, & zip):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Contact _____</p> <p>Title: _____</p> <p>Phone: _____ Ext. _____</p> <p>Fax: _____</p> <p>E-mail: _____</p>	<p>Mailing Address (incl. street, city, county, state, & zip):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Contact _____</p> <p>Title: _____</p> <p>Phone: _____ Ext. _____</p> <p>Fax: _____</p> <p>E-mail: _____</p>	<p>Mailing Address (incl. street, city, county, state, & zip):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

FORM D: ADMINISTRATIVE INFORMATION - ILA

This form provides information regarding identification and contract history on the applicant, executive management, project management, governing board members, and/or principal officers. Respond to each request for information or provide the required supplemental document behind this form. If responses require multiple pages, identify the supporting pages/documentation with the applicable request.

Legal Name of Applicant: Collin County Health Care Services

Identifying Information

The applicant shall attach the following information:

- Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the applicant.

Conflict of Interest and Contract History

The applicant shall disclose any existing or potential conflict of interest relative to the performance of the requirements of this Application for Funding. Examples of potential conflicts may include an existing business or personal relationship between the applicant, its principal, or any affiliate or subcontractor, with DSHS, the participating agencies, or any other entity or person involved in any way in any project that is the subject of this Application for Funding. Similarly, any personal or business relationship between the applicant, the principals, or any affiliate or subcontractor, with any employee of DSHS, a participating agency, or their respective suppliers, must be disclosed. Any such relationship that might be perceived or represented as a conflict shall be disclosed. Failure to disclose any such relationship may be cause for contract termination or disqualification of the proposal. If, following a review of this information, it is determined by DSHS that a conflict of interest exists, the applicant may be disqualified from further consideration for the award of a contract.

1. Does anyone in the applicant organization have an existing or potential conflict of interest relative to the performance of the requirements of this Application for Funding?

YES NO

If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)

2. Has any member of applicant's executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the application due date?

YES NO

If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation.

FORM D: ADMINISTRATIVE INFORMATION – ILA - continued

3. Has applicant had a contract with DSHS within the past 24 months?

YES NO

If YES, indicate the contract number(s):

Contract Number(s)	
2009-028548-001	2009-028222-001
2008-023201-001	2008-022943-001
2008-028182-001	2008-023780-001
2008-028175-001	2008-023008-001

If NO, applicant must be able to demonstrate fiscal solvency. Submit a copy of the organization's most recently audited balance sheet, statement of income and expenses and accompanying financial footnotes DSHS will evaluate the documents that are submitted and may, at its sole discretion, reject the proposal on the grounds of the applicant's financial capability.

4. Is applicant or any member of applicant's executive management, project management, board members or principal officers:

- Delinquent on any state, federal or other debt;
- Affiliated with an organization which is delinquent on any state, federal or other debt; or
- In default on an agreed repayment schedule with any funding organization?

YES NO

If YES, please explain. (Attach no more than one additional page.)

FORM E: ORGANIZATION, RESOURCES AND CAPACITY

Organizational Chart Attached.

FORM F: PERFORMANCE MEASURES

In the event a contract is awarded, applicant agrees that performance measures will be used to assess, in part, the applicant's effectiveness in providing the services described.

1. 90% of cases and suspects under treatment in 2009 are on DOT.
2. 92% of eligible* TB cases reported in 2008, completed a course of curative TB treatment within twelve (12) months of initiation of treatment;
3. 97% of TB patients reported in 2008 with initial positive cultures are tested for and have drug susceptibility results documented in their medical record;
4. 94% of smear positive TB cases reported in 2009 have at least one (1) contact identified;
5. 76% of identified contacts to smear positive TB cases reported in 2008 shall be evaluated for TB infection or disease;
6. 68% of infected contacts (to smear positive cases reported in 2008) who are started on treatment for LTBI shall complete therapy;
7. 75% of adults (age>14) with TB disease reported in 2009 are tested for HIV;
8. 85% of adults (age 25-44) with TB disease reported in 2009 are tested for HIV;
9. Number of TB cases in US-born non-Hispanic African-Americans

* Exclude TB cases 1) diagnosed at death, 2) who die during therapy, 3) who are resistant to rifampin, 4) who have meningeal disease, and 5) who are younger than 15 years with either miliary disease or a positive blood culture for TB.

If the contractor fails to meet any of the performance measures, the CONTRACTOR shall furnish in the narrative report due March 1, 2010, a written explanation including a plan to meet those measures.

The Infectious Disease Intervention and Control Branch Tuberculosis Prevention and Control Program shall calculate performance measures based on the information maintained in databases kept at the Tuberculosis Prevention and Control Program, through limited scope audits or inspections, and scheduled program reviews of successful applicants.

FORM G: WORK PLAN

Applicant shall describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments. Address the required elements (see WORK PLAN Requirements) associated with the services proposed in this proposal.

A maximum of five (5) additional pages may be attached if needed.

- 1. Summarize the proposed services, service area, population to be served, location (counties to be served), etc. List subcontractors you will work with in your area. Also, address if and how you will serve individuals from counties outside your stated service area.**

The proposed service area for the TB Program is Collin County, Texas. Collin County is located in North Texas, and is part of the rapidly growing Dallas/Fort Worth Metroplex. Collin County continues to be one of the fastest growing counties in the United States (28th according to the U.S. Census Bureau) and the third fastest growing county in Texas with an increase of 47.4% or 233,225 new residents in the past seven years. To put this explosive growth into perspective, Collin County's population increases by over 90 new residents each day.

Collin County is a combination of suburban/rural. Of the 885 sq. miles of Collin County, 548 sq. miles are unincorporated areas. The well-established larger cities of Plano, Frisco, Allen and McKinney, located in the southwestern quadrant of the county experienced a single digit growth rate. This suburban area is becoming close to being built out. The rural cities of Anna, Farmersville, Lavon, Melissa, Lucas and Prosper growth exceeded 15% in the past year and continued growth is expected, with much undeveloped land available.

Subcontractors are the Collin County jail and North Texas Job Corps Center. We only serve people outside the county if they work in Collin County and the proximity to our clinic will enhance compliance. Proposed services include: TST for public and contacts, medical care for TB cases and DOT for same, provision of LTBI therapy and monitoring, contact investigations for other official entities, education of medical and professional personnel.

- 2. Describe delivery systems, workforce (attach organization chart), policies, support systems (i.e. training, research, technical assistance information, financial and administrative systems and other infrastructure available to achieve service delivery and policy-making activities. What resources do you have to perform the project, who will deliver services and how will they be delivered?**

The TB Program is one of the programs offered through Collin County Health Care. The program currently has a staff of 7 (3 RNs and 3 Outreach workers and a Contact Investigator), as well as a physician who spends approximately 30% of her time on the TB Program. The clinic is open for business M-F from 8-11 and 1-4. DOT is accomplished by the two outreach workers.

With the current caseload of 33 at the end of April, the staff is greatly challenged to perform adequate service delivery. This fiscal year, thus far (Sept.-March) there have been a total of 1,048 TB office visits and 2,398 DOT home visits.

All new staff received training from the TB Program manager. The clinic and DOT workers have been properly trained in all aspects of the TB program. The DOT staff is committed to serve those clients on a daily basis and coordinates their functions with one of the TB nurses.

There are current policies and procedures in place and they are updated annually. Also, the TB Program manager gives an annual in-service to all staff regarding the program.

ORGANIZATION CHART ATTACHED.

- 3. Describe how you will determine the number of persons who received from the CONTRACTOR in 2008 at least one TB service including but not limited to tuberculin skin tests, chest radiographs, health care worker services, or treatment with one or more anti-tuberculosis medications.**

Health Care has good record-keeping of all the services it performs in the TB Program. The program manager and epidemiologist track the services through the TB data base which captures information from each data field on TB 400. The chest radiographs are paid monthly and this information is kept by the secretary who submits requisitions for payment.

- 4. Describe how data is collected and tabulated, who will be responsible for data collection and reporting, and how often data collection activities will occur. Describe how you will conduct community surveillance, to identify unreported cases of TB and individuals suspected of having TB infection. Describe how you will maintain a record of outbreaks, in your area, with a description of the outbreak and how it was managed.**

TB Data Collection

Collin County Epidemiology and Surveillance works closely with the TB division to ensure prompt reporting of TB and LTBI. Regular outreach to physicians occurs through the dissemination of a monthly newsletter related to all notifiable conditions. The monthly newsletter is faxed to physicians and includes methods for reporting notifiable conditions including TB.

Epidemiology and Surveillance maintains a database of all open and closed TB and LTBI cases. Data fields are taken from the TB 400. Data is entered when a case is reported and is completed when the case is closed. Other forms used for data collection are the TB 340, the initial case report, toxicity checks and DOT outreach patient status.

Community surveillance is conducted at several sites and by several stakeholders in Collin County. North Texas Job Corps performs TB skin testing on all admissions to their campus. CCHCS coordinates treatment of all identified cases of LTBI at Job Corps and ensures successful transfer of cases that leave the Job Corps program prior to completing full treatment for LTBI. TB skin tests are also provided at the Samaritan Inn, a homeless shelter in Collin County. Day Care providers are required to be skin tested prior to working in a day care facility. Health Care workers are assessed by the facility at which they are employed and positive skin tests are reported to CCHCS.

An outbreak of TB in Collin County would be defined as more than one case of active TB in a household or other identifiable cohort, with contact known to spread TB (i.e. a workplace with shared transportation.) An outbreak would be handled by TST of all contacts and treatment for LTBI as indicated by current practice standards.

CCHC has treated several outbreak occurrences. This example shows of how CCHCS recently worked a TB outbreak that occurred within an extended family. The index case was the patriarch of this family who lived in crowded conditions in one trailer house in a rural area. Contact investigation in the home of the index case showed that he lived with his wife; his married daughter, her husband and infant son; a young adult daughter, and a daughter still in high school. The infant grandson was admitted to Children's hospital and treated for active TB. The other five people in the home were treated for LTBI. The adult son of the index case lived with his family which included his wife, 6 year old son, 4 year old son and one year old daughter in another residence. Very quickly it was realized that the 6 year old grandson spent lots of time at the home of his grandfather (the index case) after school. Due to his symptoms he was admitted to Children's Hospital, worked up and started on four drug therapy. His four year old brother and one year old sister were admitted for workup as well, and identified as cases after the one year old had gastric aspirates positive for MTB. Because the 6 year was a public school student, an extensive contact investigation was carried out at the school. Five of the children were identified as LTBI and were treated with nine months of INH therapy. Three adults at the school were also treated for LTBI. The only family member who never converted her TST was the daughter-in-law who lived in the second residence. All contacts completed appropriate therapy except the adult son of the index case, and the son-in-law who lived in the same house with him. They started INH, but did not complete the full regimen.

- 5. Describe coordination with the other health and human services providers in the service area(s) and delineate how duplication of services is to be avoided. List other community programs you will be**

working with in your jurisdiction (community based organizations, private providers, hospitals, and service organizations).

Collin County Health Care Services works closely with neighboring health departments and the Region 2/3 office of the Department of State Health Services to co-ordinate transfers of cases reported to CCHCS but residing outside of the county. Co-ordination is also important for persons who may begin care for LTBI at Job Corps but leave the program to return to their previous residence. In such cases information is shared by fax and telephone with the appropriate personnel at the receiving health department.

Also, CCHC works closely with the Infection Control Providers of all hospitals in the area. These professionals provide early warning and documentation of possible TB cases. Clinic personnel attempt to make contact with in-patients as appropriate to start education and contact investigation. This vital link is essential in keeping up to date with potential cases and problems that may be presented.

When a case investigation yields contacts residing in other counties CCHS will coordinate services such as TST and Chest X-rays to ensure that services are provided and that appropriate follow-up is arranged as necessary.

6. Describe ability to provide services to culturally diverse populations (e.g. use of interpreter services, language translation, compliance with ADA requirements, location, hours of service delivery, and other means to ensure accessibility for the defined population).

Full range of service is available in Spanish, including consents, educational material, phone service, and clinical management. Also, we have several Spanish-speaking staff members. Most other languages are available in educational materials via the internet or through the telephone translation service, Language Lines. Collin County Health Care's offices are fully compliant with ADA regulations and we have successfully provided long term service to paraplegic patients.

We have recently begun utilization of new CDC (2008) Guidelines Promoting Cultural Sensitivity booklets. The clinic has added discussion of these various cultures and their needs into our routine staff meetings. It is interesting to see the correlation with our own patients from these countries.

7. Describe your strategy for the management of TB cases and suspects, with emphasis on provision of directly observed therapy (DOT).

Collin County Health Care has three FTEs dedicated to the delivery and management of DOT. Each of these employees has use of a county vehicle and delivers DOT directly to the patient's home or worksite, doing careful observation and monitoring of adverse signs and symptoms while administering the medications. They each have phone contact available directly to the TB Program Manager and the physician in case of adverse reactions or questions regarding medication administration.

8. Describe your strategy for the management of contacts and positive reactors, with emphasis on directly observed preventive therapy (DOPT).

High-priority contacts should have an initial encounter within 7 business days from identification and medium-priority contacts should have an initial encounter within 14 business days from identification. The following will also get CXR provided by CCHC: any reading >5mm, and any child under the age of 5 years. Any contact with a positive TST will be offered LTBI treatment and monitored closely through the duration of the regimen. Any contact under the age of 5 years will be treated with DOPT INH under the direction of their pediatric PCP and administered by CCHC employees.

9. Describe your infection control procedures.

Universal precautions are observed in all areas of care for the patient. This includes hand washing, blood borne precautions, and respiratory precautions. Respiratory control measures consist of both engineering controls and personal respiratory protection.

Engineering control is managed at Collin County Health Care Services with the use of two designated rooms equipped with HEPA systems. The system provides 100% recirculation of the negative air flow that is produced in the rooms. The system is operated a minimum of one hour after a patient with infectious TB leaves the room. The

system is inspected once per month by Facilities Management at Collin County.

Personal protection begins with all Collin County Health Care Services staff receiving annual TST. TB Clinic staff are tested every six months. All TB Clinic staff and any other employee who might have contact with active cases (front desk personnel, interpreters, etc.) are fit tested for N95 respirators and instructed in their proper use. Collin County health care workers mask when they are in face-to-face contact with a known infectious case and when they perform procedures such as sputum collection or induction.

10. Describe plans to conduct targeted TB screening programs for high-risk populations.

The TB Program Manager targets screening on a regular basis at the Samaritan Inn, a homeless shelter in McKinney.

11. Describe your strategy to provide professional education and training programs for new and current TB staff.

Education of the TB staff is an ongoing process. New clinical employees are required to work through the CDC Core Curriculum on Tuberculosis, 2000 immediately and then to complete the updated on-line version after a fair maturation process. New TB Outreach Workers (DOT) staff are required to have 40 hours of classroom instruction and 40 hours of field work instruction. Learning is documented by a pre-test and post-test process, as well as use of a preceptor in the field.

Targeted TB in-service programming is planned at least once annually for the entire TB staff. Clinical staff are scheduled to attend professional conferences as they become available.

12. Describe the internal program evaluation process utilized to monitor services, identify staff that utilize them and who is responsible for ensuring they are updated. The description shall include the following 1) role of a program evaluation committee; 2) medical director's involvement in the program evaluation activities; 3) activities utilized to identify trends of needed improvement and the frequency of those activities; 4) activities to ensure correction and follow-up to findings identified; 5) utilization and frequency of client satisfaction surveys; 6) system utilized to identify and monitor adverse outcomes; 7) process for identifying performance and outcome measures; and 8) process utilized to develop protocols and standing delegation orders.

The program evaluation committee ensures that TB and LTBI cases are appropriately identified, investigated and served in an accurate and timely manner. The program evaluation committee consists of the Health Department Director, Collin County Health Authority (medical director), TB Coordinator, and individual staff members. The Collin County Health Authority is directly responsible for the provision of medical care to TB cases in Collin County and oversees TB records. Review of records allows the HA to identify and monitor potential adverse outcomes.

Performance measures for staff are identified through the Pay for Performance system used by all HD staff. Trends that indicated needed improvement are identified at least twice yearly through interim evaluation of staff. Outcome measures for the program are provided by DSHS. Outcome measures for individual staff members are agreed upon by the direct supervisor of the staff and the staff member.

Protocols and Procedures have been developed and are reviewed annually by the Health Authority. Any changes or additions are approved by the health Authority. At implementation all HD staff are required to review and acknowledge that the new policies/orders are in place.

According to a 2006 economic study conducted by UNTHSC School of Medicine, School of Public Health, the total average cost per tuberculosis patient is \$20,269 in Collin County. The average transmission for pulmonary tuberculosis results in 1.2 cases per index case. Each tuberculosis case that is **not** prevented yields approximately \$81,000 in future societal costs. Interdicting just 12 cases can save over \$1.16 million in future societal costs. They estimated that ninety-nine preventive treatments given for LTBI's will prevent seven new cases, thus preventing approximately \$567,000 in future societal cost. With this economic documentation in mind, Collin County Health Care strives to carry out their mission of preventing, controlling, and eliminating the spread of tuberculosis within the county.

13. Describe your strategy to document the evaluation of immigrants and refugees with the following

notifications: Class A (Applicants who have tuberculosis disease diagnosed (sputum smear positive or culture positive) and require treatment overseas but who have been granted a waiver to travel prior to the completion of therapy.); Class B1 – Pulmonary (No treatment: - Applicants who have medical history, physical exam, or CXR findings suggestive of pulmonary tuberculosis but have negative AFB sputum smears and cultures and are not diagnosed with tuberculosis or can wait to have tuberculosis treatment started after immigration. Completed treatment: - Applicants who were diagnosed with pulmonary tuberculosis and successfully completed directly observed therapy prior to immigration.); Class B1 – Extrapulmonary (evidence of extrapulmonary tuberculosis); Class B2 (LTBI Evaluation – Applicants who have a tuberculin skin test > 10 mm but who otherwise have a negative evaluation for tuberculosis.); Class B3 Contact Evaluation – applicants who are a contact of a known tuberculosis case.)

STRATEGY TO DOCUMENT THE EVALUATION OF CLASSIFIED-IMMIGRANTS AND REFUGEES BEGINNING OCTOBER 2009

Immigrants who enter the county with a designation of Class A, Class B-1, or Class B-2, must be seen in the TB Clinic and evaluated by the Collin County Health Authority.

Class A Immigrants: Active Disease, Current Treatment

CCHCS RESPONSE

A TB400A and TB400B will be submitted to the state which documents current treatment and follow-up.

Class B-1 Immigrants: Pulmonary, No Treatment; Completed Treatment; and Extrapulmonary.

CCHCS RESPONSE

A TB400A and TB400B will be submitted that either rules out TB disease, thus a closure code of non-TB will be submitted, or; a TB 400A and B with the new change in ATS classification will be submitted. This will be done after the following is begun:

1. Review TST status. If documentation is not available, a TST will be administered. TST results will be evaluated as per ATS/CDC guidelines.
2. A current chest x-ray is taken and compared with the film from overseas.
3. Past TB treatment history is reviewed.
4. Collection of sputum for testing on three consecutive days. One collection will be observed by clinic staff.
5. Medication is prescribed as appropriate per ATS/CDC guidelines.
6. Follow up as appropriate per ATS/CDC guidelines.

Class B-2 Immigrants: LTBI Evaluation

CCHCS RESPONSE

A TB400A and TB400B will be submitted that either rules out TB disease, thus a closure code of non-TB will be submitted, or a TB 400A and B with the new change in ATS classification will be submitted. This will be done after the following is begun:

1. Review TST status. If documentation is not available, a TST will be administered. TST results will be evaluated per ATS/CDC guidelines.
2. A current chest x-ray is taken and compared with the film from overseas.
3. Past TB treatment history is reviewed.
4. Collection of sputum for testing on three consecutive days if deemed necessary by provider.
5. Medication is prescribed as appropriate per ATS/CDC guidelines.
6. Follow up as appropriate per ATS/CDC guidelines.

Class B-3 Immigrants: Contact Evaluation

CCHCS RESPONSE

Immigrants who enter the county with a designation of Class B-3 must be seen in the TB Clinic and followed as a contact.

A form TB 340 will be submitted with information regarding the Contact Investigation and any treatment given.

*As funding permits, interferon gamma based blood test may be used in selective cases of all above categories when requested by Health Authority.

FORM G-1: WORK PLAN Guidelines

Applicant shall describe its plan for service delivery to the population in the proposed service area(s) and include time lines for accomplishments. The work plan shall address the needs and the problems identified in the community assessment for improving health status. The plan shall:

1. Summarize the proposed services, service area, population to be served, location (counties to be served), etc. List subcontractors you will work with in your area. Also, address if and how you will serve individuals from counties outside your stated service area.
2. Describe delivery systems, workforce (attach organizational chart), policies, support systems (i.e., training, research, technical assistance, information, financial and administrative systems) and other infrastructure available to achieve service delivery and policy-making activities. What resources do you have to perform the project, who will deliver services and how will they be delivered?
3. Determine the number of persons who received from the CONTRACTOR in 2009 at least one TB service including but not limited to tuberculin skin tests, chest radiographs, health care worker services, or treatment with one or more anti-tuberculosis medications.
4. Describe how data is collected and tabulated, who will be responsible for data collection and reporting, and how often data collection activities will occur. Describe how you will conduct community surveillance, to identify unreported cases of TB and individuals suspected of having TB infection. Describe how you will maintain a record of outbreaks, in your area, with a description of the outbreak and how it was managed.
5. Describe coordination with the other health and human services providers in the service area(s) and delineate how duplication of services is to be avoided. List other community programs you will be working with in your jurisdiction (community based organizations, private providers, hospitals, and service organizations).
6. Describe ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with ADA requirements, location, hours of service delivery, and other means to ensure accessibility for the defined population).
7. Describe your strategy for the management of TB cases and suspects, with emphasis on provision of directly observed therapy (DOT).
8. Describe your strategy for the management of contacts and positive reactors, with emphasis on directly observed preventive therapy (DOPT).
9. Describe your infection control procedures.
10. Describe plans to conduct targeted TB screening programs for high-risk populations.
11. Describe your strategy to provide professional education and training programs for new and current TB staff.
12. Describe the internal program evaluation process utilized to monitor services, identify staff that utilize them and who is responsible for ensuring they are updated. The description shall include the following 1) role of a program evaluation committee; 2) medical director's involvement in the program evaluation activities; 3) activities utilized to identify trends of needed improvement and the frequency of those activities; 4) activities to ensure correction and follow-up to findings identified; 5) utilization and frequency of client satisfaction surveys; 6) system utilized to identify and monitor adverse outcomes; 7) process for identifying performance and outcome measures; and 8) process utilized to develop protocols and standing delegation orders.

Describe your strategy to document the evaluation of immigrants and refugees with the following notifications: Class A (Applicants who have tuberculosis disease diagnosed [sputum smear positive or culture positive] and require treatment overseas but who have been granted a waiver to travel prior to the completion of therapy.); Class B1 – Pulmonary (No treatment: - Applicants who have medical history, physical exam, or CXR findings suggestive of pulmonary tuberculosis but have negative AFB sputum smears and cultures and are not diagnosed with tuberculosis or can wait to have tuberculosis treatment started after immigration. Completed treatment: - Applicants who were diagnosed with pulmonary tuberculosis and successfully completed directly observed therapy prior to immigration.); Class B1 – Extra pulmonary (evidence of extra pulmonary tuberculosis); Class B2 (LTBI Evaluation – Applicants who have a tuberculin skin test ≥ 10 mm but who otherwise have a negative evaluation for tuberculosis.); Class B3 (Contact Evaluation – applicants who are a contact of a known tuberculosis c

FORM H: APPENDICES

APPENDIX A DSHS ASSURANCES AND CERTIFICATIONS

As the duly authorized representative of the applicant, my signature on the FACE PAGE Form certifies that the applicant:

1. Has the legal authority to apply for state/federal assistance, and the institutional, managerial and financial capability and systems (including funds sufficient to pay the non-state/federal share of project costs) to ensure proper planning, management and completion of the project described in this application;
2. Has a financial system that demonstrates accounting, budgetary and internal controls; cash management; reporting capability; cost allowability determination; and source documentation;
3. Will give DSHS, the Texas State Auditor, the Comptroller General of the United States, and if appropriate, the federal government, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives;
4. Will supplement the project/activity with funds made available through a contract award as a result of this ILA and will not supplant funds;
5. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain;
6. Will comply, as a subgrantee, with Texas Government Code, Chapter 573, Vernon's 1994, by ensuring that no officer, employee, or member of the applicant's governing body or of the applicant's contractor shall vote or confirm the employment of any person related within the second degree of affinity or the third degree of consanguinity to any member of the governing body or to any other officer or employee authorized to employ or supervise such person. This prohibition shall not prohibit the employment of a person who shall have been continuously employed for a period of two years, or such other period stipulated by local law, prior to the election or appointment of the officer, employee, or governing body member related to such person in the prohibited degree;
7. Affirms that it has not given, nor intends to give, at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement;
8. Will honor for 90 days after the application due date the technical and business terms contained in the application;
9. Will initiate the work after receipt of a fully executed contract and will complete it within the contract period;
10. Will not require a client to provide or pay for the services of a translator or interpreter;
11. Will identify and document on client records the primary language/dialect of a client who has limited English proficiency and the need for translation or interpretation services;
12. Will make every effort to avoid use of any persons under the age of 18 or any family member or friend of a client as an interpreter for essential communications with clients who have limited English proficiency. However, a family member or friend may be used as an interpreter if this is requested by the client and the use of such a person would not compromise the effectiveness of services or violates the clients confidentiality, and the client is advised that a free interpreter is available;
13. Will comply with the requirements of the Immigration Reform and Control Act of 1986, 8 USC §1324a, as amended, regarding employment verification and retention of verification forms for any individual(s) hired on or after November 6, 1986, who will perform any labor or services proposed in this application;

FORM H: APPENDICES continued

14. Agrees to comply with the following to the extent such provisions are applicable:
 - A. Title VI of the Civil Rights Act of 1964, 42 USC §§2000d, et seq.;
 - B. Section 504 of the Rehabilitation Act of 1973, 29 USC §794(a);
 - C. The Americans with Disabilities Act of 1990, 42 USC §§12101, et seq.;
 - D. All amendments to each and all requirements imposed by the regulations issued pursuant to these acts, especially 45 CFR Part 80 (relating to race, color and national origin), 45 CFR Part 84 (relating to handicap), 45 CFR Part 86 (relating to sex), and 45 CFR Part 91 (relating to age); and
 - E. DSHS Policy XO-0119, Non-Discrimination Policies and Procedures for DSHS Programs, which prohibits discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, age, or disability;
15. Will comply with the Uniform Grant Management Act (UGCMA), Texas Government Code, Chapter 783, as amended, and the Uniform Grant Management Standards (UGMS), as amended by revised federal circulars and incorporated in UGMS by the Governor's Budget and Planning Office, which apply as terms and conditions of any resulting contract. A copy of the UGMS manual and its references are available upon request;
16. Will comply with the non-discriminatory requirements of Texas Labor Code, Chapter 21, which requires that certain employers not discriminate on the basis of race, color, disability, religion, sex, national origin, or age;
17. Will comply with environmental standards prescribed pursuant to the following:
 - A. Institution of environmental quality control measures under the National Environmental Policy Act of 1969, 42 USC §§4321-4347, and Executive Order (EO) 11514 (35 Fed. Reg. 4247), "Protection and Enhancement of Environmental Quality;"
 - B. Notification of violating facilities pursuant to EO 11738 (40 CFR, Part 32), "Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants or Loans;"
 - C. Conformity of federal actions to state clean air implementation plans under the Clean Air Act of 1955, as amended, 42 USC §§7401 et seq.; and
 - D. Protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, 42 USC §§300f-300j, as amended;
18. Will comply with the Pro-Children Act of 1994, 20 USC §§6081-6084, regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
19. Will comply, if applicable, with National Research Service Award Act of 1971, 42 USC §§289a-1 et seq., as amended and 6601 (P.L. 93-348 – P.L. 103-43), as amended, regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance, as implemented by 45 CFR Part 46, Protection of Human Subjects;
20. Will comply, if applicable, with the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 USC §263a, as amended, which establish federal requirements for the regulation and certification of clinical laboratories;
21. Will comply, if applicable, with the Occupational Safety and Health Administration Regulations on Blood-borne Pathogens, 29 CFR §1919.030, which set safety standards for those workers and facilities in the private sector who may handle blood-borne pathogens, or Title 25 Texas Administrative Code, Chapter 96, which affects facilities in the public sector;
22. Will comply with all applicable requirements of all other state/federal laws, executive orders, regulations, and policies governing this program;

FORM H: APPENDICES continued

23. Defined as the primary participant in accordance with 45 CFR Part 76, and his/her principals:
- A. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency;
 - B. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 - C. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
 - D. has not within a 3-year period preceding this application/proposal had one or more public transactions (federal, state, or local) terminated for cause or default.

Should the applicant not be able to provide this certification (by signing the FACE PAGE Form), an explanation should be placed after this form in the application response.

The applicant agrees by submitting this proposal that he/she will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transaction" (Appendix B to 45 CFR Part 76) in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions;

24. Understands that Title 31, USC §1352, entitled "Limitation on use of appropriated funds to influence certain federal contracting and financial transactions," generally prohibits recipients of federal grants and cooperative agreements from using federal (appropriated) funds for lobbying the executive or legislative branches of the federal government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a federal grant or cooperative agreement must disclose lobbying undertaken with non-federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).
- A. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement;
 - B. If any funds other than federally-appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agent, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," (SF-LLL) in accordance with its instructions. SF-LLL and continuation sheet are available upon request from the Department of State Health Services; and
 - C. The language of this certification shall be included in the award documents for all sub-awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly;

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by USC §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure; and

FORM H: APPENDICES continued

25. Affirms that the statements herein are true, accurate, and complete (to the best of his or her knowledge and belief), and agrees to comply with the DSHS terms and conditions if an award is issued as a result of this application. Willful provision of false information is a criminal offense (Title 18, USC §1001). Any person making any false, fictitious, or fraudulent statement may, in addition to other remedies available to the Government, be subject to civil penalties under the Program Fraud Civil Remedies Act of 1986 (45 CFR Part 79).

General Instructions for Completing Budget Forms

In preparing the budget, you should budget for all costs that your organization will incur in carrying out the DSHS program. After you have identified all costs in each budget category on the respective budget category forms, the total for each budget category form will automatically populate the budget summary page; giving you a total budget. Next, you will need to determine how much of the total budget will be funded by your organization and other funding sources. For example, if the total budget is \$200,000 and your organization plans to fund \$100,000, then on the Budget Summary page, place 50% in column 2 (DSHS Funds Requested) and 50% in column 5 (Local Funding Sources).

DSHS does not view specific items in a budget category as either being funded by DSHS or the contractor; we look at the total costs of the program as a whole and the percentage of the total (across all budget categories) to be funded by DSHS and other funding sources. When contractors report costs to DSHS on the Financial Status Report (FSR), they are not required to break out costs by funding source; costs are reported in total by budget category. Likewise, contractors are not required to budget specific costs within a budget category by funding source. We understand that under some contractor's accounting systems, costs allocable to the DSHS program are budgeted in (for example) the general fund or restricted funds may be used. In this case, to arrive at the percentage of "Local Funding", isolate the total amount to be funded by the general fund or restricted fund and use this amount to calculate the percentage being funded by your organization.

Actual costs charged to a non-DSHS program cost center that benefit the DSHS program must either be reclassified to the DSHS program cost center or be isolated in a unique series of accounts within the non-DSHS program cost center (i.e. general fund). Both federal and state regulations applicable to grants require that costs incurred in support of a grant funded activity be identified and be traceable. Costs recorded in the general ledger must be based on actual costs and cannot be based on budgets or estimates.

Other guidance:

- Be sure to read the instructions for each budget form
- Look at the examples before completing the forms
- Enter the name of your organization once on the Budget Summary Page; it will populate all of the other forms.
- Do not change the format of any of the unlocked cells.

FORM I: BUDGET SUMMARY INSTRUCTIONS

An accurate budget plan is essential to achieve the performance measures and work plan set out in the narrative portion of the RFP. Be sure to refer to the appropriate sections in the RFP for program-specific allowable and unallowable costs. The total amounts budgeted on this form must reflect funding from all sources that support the project described in this RFP. See individual "Detailed Budget Category Forms" for definitions of the cost that are to be budgeted in each category. Enter amount as whole dollars; round up.

Legal Name of Respondent: Enter the legal name of your organization; this will populate the legal name field in the detail budget pages.

For purposes of this form, the column headings have the following meanings:

Column 1: The total amount of funds budgeted from all funding sources for the DSHS project. Category totals will be automatically posted from each budget category detail form. **Do not enter amounts in Column (1) except for the amount of Program Income.**

Columns 2 - 6: **Percentage of Funding line (Columns 2-6):** Enter the percentage of the total funding that is being requested from DSHS and percentage of funding to be provided by any of the other source listed. Percentages of all funding sources must total to 100% in column 1. The percentage(s) will be applied to the total of each cost category and the respective share of funding will be automatically calculated, **with the exception of the Equipment category.** The amount of funding to be provided by DSHS and any of the other funding sources for equipment must be entered manually.

Column 3: Federal funds awarded directly to respondent to be used on the DSHS project.

Column 4: Funds awarded to respondent from other state agencies to be used on the DSHS project.

Column 5: Funds provided by local governments (city, county, hospital districts, etc)

Column 6: Funds from other sources. (respondents unrestricted funds including private foundations, donations, fundraising, etc)

Program Income - Projected Earnings (line K): Enter in Column 1 the total estimated the amount of program income that is expected to be generated during the budget period. The amount budgeted in column 1 should be the total program income that the project will generate. The proportionate share of program income will automatically allocate to each funding source based on the percentage of funding. The DSHS share of program income must be used to finance costs of the DSHS funded activity. Program income budgeted under each funding source can be used to finance costs that are in addition to those budgeted on lines A through J for each funding source.

DEFINITION: Program income is defined as gross income directly generated through a contract supported activity or earned as a direct result of the contract agreement during the Program Attachment period. Refer to the instructions section below for examples of program income. In summary, program income is revenue generated by virtue of the existence of the program (activities funded under the DSHS Program Attachment).

Contractor must disburse (apply towards gross Program Attachment expenses) the DSHS share of program income before requesting reimbursement.

For more information about program income, refer to the General Provisions and the DSHS's Contractor's Financial Procedures Manual available on the Internet at: <http://www.dshs.state.tx.us/contracts/docs/cfpm.doc>.

Examples Of Program Income

- Fees for services performed in connection with and during the period of contract support;
- Tuition and fees when the course of instruction is developed, sponsored, and supported by DSHS contract;
- Sale of items fabricated or developed under the contract supported activity;
- Payments for contract supported services received from patients or third parties, such as Medicaid, Title XX, insurance companies;
- Lease or rental of items fabricated or developed under the contract supported activity; and
- Rights or royalty payments resulting from patents or copyrights developed or acquired by the contractor.

FORM I: BUDGET SUMMARY EXAMPLE

Legal Name of Respondent: Apple County Health Department

Cost Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
Percentage of Funding	100.00%	40.00%	30.00%	10.00%	15.00%	5.00%
A. Personnel	\$40,620	\$16,248	\$12,186	\$4,062	\$6,093	\$2,031
B. Fringe Benefits	\$9,249	\$3,700	\$2,775	\$925	\$1,387	\$462
C. Travel	\$1,091	\$437	\$327	\$109	\$164	\$55
D. Equipment	\$5,250	\$5,250				
E. Supplies	\$39,000	\$15,600	\$11,700	\$3,900	\$5,850	\$1,950
F. Contractual	\$41,208	\$16,483	\$12,362	\$4,121	\$6,181	\$2,060
G. Other	\$8,250	\$3,300	\$2,475	\$825	\$1,238	\$413
H. Total Direct Costs	\$144,668	\$61,017	\$41,826	\$13,942	\$20,913	\$6,971
I. Indirect Costs	\$3,575	\$1,430	\$1,073	\$358	\$536	\$179
J. Total (Sum of H and I)	\$148,243	\$62,447	\$42,898	\$14,299	\$21,449	\$7,150
K. Program Income - Projected Earnings	\$13,000	\$5,200	\$3,900	\$1,300	\$1,950	\$650

*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: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent:

Collin County Health Care Services

Cost Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
Percentage of Funding	99%	34%		6%	60%	
A. Personnel	\$332,190	\$112,546	\$0	\$18,270	\$199,314	\$0
B. Fringe Benefits	\$107,497	\$36,420	\$0	\$5,912	\$64,498	\$0
C. Travel	\$11,033	\$3,738	\$0	\$607	\$6,620	\$0
D. Equipment	\$0	\$0	\$0	\$0	\$0	\$0
E. Supplies	\$1,600	\$542	\$0	\$88	\$960	\$0
F. Contractual	\$12,806	\$4,339	\$0	\$704	\$7,684	\$0
G. Other	\$329	\$111	\$0	\$18	\$197	\$0
H. Total Direct Costs	\$465,455	\$157,696	\$0	\$25,599	\$279,273	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$465,455	\$157,696	\$0	\$25,599	\$279,273	\$0
K. Program Income - Projected Earnings		\$0	\$0	\$0	\$0	\$0

NOTE: The "Total Budget" amount for the Equipment and Indirect Costs Categories 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 "Total Budget" amount (column 1) equals the "Check Total" below.

Check Total For: Equipment = \$0 Indirect Costs = \$0

*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 Instructions

PERSONNEL

DEFINITION: The actual cost of salaries and wages of employees devoted to working on activities directly related to carrying out the Scope of Work of the DSHS funded project. These costs are allowable to the extent that they are reasonable and conform to the established, consistently applied policy of the organization and reflect no more than the time actually devoted to the project. The salaries and wages of employees that do not work on activities described in the the Scope of Work of the DSHS funded project should be allocated as indirect costs and budgeted under the Indirect Cost category.

INSTRUCTIONS - Enter the following information for each position on the PERSONNEL Budget Category Detail Form:

Personnel - enter the functional title, whether the position is existing (E) or proposed (P);

Vacant Y/N - indicate whether the position is vacant (Y) or filled (N);

Justification - include a brief description of the position's primary responsibilities and an explanation for the % of time dedicated to the project, why the position classification is appropriate (including license/certification requirements);

FTE's (Full Time Equivalents) - enter the number of FTE's for the functional title that will be working on the DSHS funded project; FTE is the total number of hours worked (budgeted) for the DSHS project divided by the compensable hours (2080) in a fiscal year;

Certification/License Required - any certification or license an individual must possess to be qualified for the position;

Total Average Monthly SalaryWage - the total average monthly salary/wage of FTE's budgeted for this functional title;

Number of Months: Enter the number of months that his position will be working on the DSHS project.

Salary/Wages Requested for Project - the amount will be computed automatically by multiplying number of FTE's by Total Annual Salary

FRINGE BENEFITS

DEFINITION: Fringe benefits are allowances and services provided by the organization to its employees as compensation in addition to regular salaries and wages. Fringe benefits include but are not limited to the cost of employee insurance, pensions, and unemployment benefit plans. The cost of fringe benefits is allowable (in proportion to the amount of time or effort employees devote to the grant funded project), to the extent that the benefits are reasonable and are incurred under formally established and consistently applied policies of the organization.

INSTRUCTIONS:

Fringe Benefits -List the types of costs that comprise your organizations fringe benefits;

Fringe Benefit Rate -The fringe benefit rate should be based on your organizations actual experience. The fringe benefit rate is typically calculated by dividing your organizations total fringe benefit costs by total wage/salary costs. Enter your organizations fringe benefit rate on the budget sheet;

Fringe Benefits Total - the total fringe benefit amount will be automatically calculated by multiplying the rate times the salary total.

FORM I-1: PERSONNEL Budget Category Detail Form Example

Legal Name of Respondent: Apple County Health Department

PERSONNEL		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									
Program Director (E)	Provides programmatic oversight and programmatic accountability of organization.	N		0.05	CPS	\$4,200	12	\$2,520	
Case Manager (P)	Provides case management services and training.	Y		0.05	LMSW	\$3,500	12	\$2,100	
Outreach Counselor (E)	Provides outreach/case management services.	N		1	LCDC	\$3,000	12	\$36,000	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
								\$0	
Salary/Wage Total									\$40,620

FRINGE BENEFITS

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space.

FICA, Worker's Comp, Retirement Plan, Health Insurance

	Fringe Benefit Rate %
	22.77%

	Fringe Benefits Total
	\$9,249

FORM I-2: TRAVEL Budget Category Instructions

DEFINITION: The cost of transportation, lodging, meals and related expenses incurred by employees of the organization while performing duties relevant to the proposed project. This includes auto mileage paid to employees on the basis of a fixed mileage rate for the use of their personal vehicle. Costs related to client transportation and conference registration fees should be classified under the "Other" expense category. Travel costs incurred by a third party under contract should be included within the terms of the contract and be budgeted under the "Contractual" expense category.

INSTRUCTIONS: The TRAVEL Budget Category Detail Form requires information on conferences/workshops and local travel costs pertaining to the DSHS project. Note: Conference registration fees should be budgeted under the "Other" budget category.

For conferences/workshops, the following information must be provided:

Description of Conference/Workshop - the name and/or description of the conference/workshop;

Justification - the justification should include how attendance at the conference/workshop will directly benefit the project and why it is necessary to accomplish the project;

Location - the location (city/state) where the conference/workshop will be held;

Number of: Days/Employees - number days and employees attending the conference/workshop;

Travel Costs - (for each conference/workshop)

Mileage - the estimated cost of mileage reimbursement

Airfare - the estimated cost of airfare

Meals - the cost of meals

Lodging - the cost of lodging

Other Costs - such as: parking/toll fees, rental car, gasoline for rental car, ground transportation (Does not include conference registration)

For local travel, the following information must be provided:

Justification - provide a justification for the local travel and why the travel is necessary to accomplish the project, include the name of the person or position classification(s) that will be traveling;

Number of Miles - the estimated number of miles to be traveled for the budget period;

Mileage Reimbursement Rate - enter the mileage reimbursement rate;

Mileage Cost - will calculate automatically (do not enter an amount in this column);

Other Costs - such as parking fees, toll fees

Total - will be calculated automatically (do not enter an amount into this column).

The amounts at the bottom of the form for "Other/Local Travel Costs", "Conference/Workshop Travel Costs", and "Total Travel Costs" will be

Indicate Policy Used: Indicate policy being used by marking one of box.

All contracts with the Department of State Health Services require that a written travel policy be maintained by the contracting entity and available for review by DSHS staff upon request. If a written travel policy is not in place, State of Texas Travel Policy will be applied; available at: <https://fmx.cpa.state.tx.us/fmx/travel/index.php> .

FORM I-2: TRAVEL Budget Category Detail Form Example

Legal Name of Respondent: Apple County Health Department

Conference / Workshop Travel Costs		Justification	Location (City, State)	Number of Days/ Employees	Travel Costs	
Description of Conference/Workshop						
Community Planning Meetings	Clinic Services Director to attend Family Planning Committee meetings.	Austin, TX	2/1	Mileage	\$172	
				Airfare	\$	
				Meals	\$75	
				Lodging	\$225	
				Other Costs		
				Mileage	\$	
				Airfare	\$	
				Meals	\$	
				Lodging	\$	
				Other Costs	\$	
Total for Conference / Workshop Travel						\$472

Other / Local Travel Costs		Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Description of Conference/Workshop	Justification				
Local travel for case workers		\$0.45	\$475	\$144	\$619
			\$0		\$0
			\$0		\$0
Total for Other / Local Travel					\$619

Other / Local Travel Costs: Conference / Workshop Travel Costs: Total Travel Costs:

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

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Collin County Health Care Services

Conference / Workshop Travel Costs	Description of Conference/Workshop	Justification	Location City/State	Number of:		Travel Costs												
				Days	Employees													
	Heartland and Nat's TB Intensive Ctr. UT Health Center	Annual update for TB Policies & Procedures (DSHS Funding) Trip is 4 days-3 nights (\$95.00 hotel per person x 3days= \$570.00) (321 miles at .55 per miles=\$353.00),(\$22.50 per day for meals times 2 people=\$180.00)	Tyler, TX	2 staff	4 days	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Mileage</td><td>\$353</td></tr> <tr><td>Airfare</td><td>\$0</td></tr> <tr><td>Meals</td><td>\$180</td></tr> <tr><td>Lodging</td><td>\$570</td></tr> <tr><td>Other Costs</td><td>\$0</td></tr> <tr><td>Total</td><td>\$1,103</td></tr> </table>	Mileage	\$353	Airfare	\$0	Meals	\$180	Lodging	\$570	Other Costs	\$0	Total	\$1,103
Mileage	\$353																	
Airfare	\$0																	
Meals	\$180																	
Lodging	\$570																	
Other Costs	\$0																	
Total	\$1,103																	
	World TB Day (DSHS Funding)	An annual event (DSHS Funding) Carpool-(500 miles at .55 per mile=\$275.00) (2 rooms at \$100.00 night= \$200.00) Meals at \$17.00 per day times 3 staff = \$102.00)	Austin, TX	3 staff	2 days	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Mileage</td><td>\$275</td></tr> <tr><td>Airfare</td><td>\$0</td></tr> <tr><td>Meals</td><td>\$100</td></tr> <tr><td>Lodging</td><td>\$200</td></tr> <tr><td>Other Costs</td><td>\$0</td></tr> <tr><td>Total</td><td>\$575</td></tr> </table>	Mileage	\$275	Airfare	\$0	Meals	\$100	Lodging	\$200	Other Costs	\$0	Total	\$575
Mileage	\$275																	
Airfare	\$0																	
Meals	\$100																	
Lodging	\$200																	
Other Costs	\$0																	
Total	\$575																	
	Program's Manager Meeting	An annual meeting for updates (DSHS Funding) Carpool- (2 staff at 500 miles at .55 per mile = \$275.00) (5 days Hotel 4 nights at \$95.00 per night = \$380.00 share a room) (Meals \$20.00 per day (5 days) time 2 staff = \$200.00)	Austin, TX	2 staff	5 days	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Mileage</td><td>\$275</td></tr> <tr><td>Airfare</td><td>\$0</td></tr> <tr><td>Meals</td><td>\$200</td></tr> <tr><td>Lodging</td><td>\$380</td></tr> <tr><td>Other Costs</td><td>\$0</td></tr> <tr><td>Total</td><td>\$855</td></tr> </table>	Mileage	\$275	Airfare	\$0	Meals	\$200	Lodging	\$380	Other Costs	\$0	Total	\$855
Mileage	\$275																	
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Mileage																		
Airfare																		
Meals																		
Lodging																		
Other Costs																		
Total	\$0																	

Total for Conference / Workshop Travel

\$2,533

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Local travel for contact investigators and DOT workers (DSHS Funding)	15455	\$0.550	\$8,500		\$8,500
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0

Total for Other / Local Travel **\$8,500**

Other / Local Travel Costs: **\$8,500**

Conference / Workshop Travel Costs: **\$2,533**

Total Travel Costs: **\$11,033**

Indicate Policy Used:

Respondent's Travel Policy

State of Texas Travel Policy

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category Instructions

DEFINITION: Equipment and Controlled Assets Purchases. Equipment means an article of nonexpendable, tangible personal property having a useful lifetime of more than one year and an acquisition cost of \$5,000 or more. Contractor must inventory equipment, and controlled assets, which include, firearms regardless of the acquisition cost, and the following assets with an acquisition cost of \$500 or more: desktop and laptop computers, non-portable printers and copiers, emergency management equipment, communication devices and systems, medical and laboratory equipment, and media equipment. If purchase of equipment is approved in writing by the Department, Contractor is required to initiate the purchase of that equipment in the first quarter of the Contract or Program Attachment term, as applicable. Failure to initiate the purchase of equipment may result in loss of availability of funds for the purchase of equipment.

INSTRUCTIONS - Enter the following information:

Description of Item - describe each line item of equipment, attach a complete specification or a copy of the purchase order;

Purpose & Justification - state the purpose for the item(s) and why the equipment is necessary; also, if a portion of the equipment cost will be funded by non-DSHS, name the funding source and the percentage of the cost being funded.

Number of Units - enter the number of units (quantity) to be purchased;

Cost Per Unit - enter the cost per unit;

Total - the total will be automatically calculated by multiplying the "Number of Units" times "Cost Per Unit".

NOTE - The "Total Amount Requested for Equipment" will automatically post to Form I - Budget Summary under the "Total Budget" column. If the cost of equipment will be funded in total by DSHS, enter the total amount under the "DSHS Funds Requested" column. If the cost of equipment will be shared with other funding sources, allocate the budgeted costs accordingly under the respective funding source column.

EXAMPLES OF EQUIPMENT DESCRIPTIONS

Remember: Equipment is priced per unit including freight. If you intend to purchase 10 modems @ \$95 each, this would be considered a supply item not an equipment item.

INCORRECT EXAMPLES

Computer-850 Mhz Pentium

1 @ \$2,150

(insufficient description/specification)

1 @ \$250 Laser Jet Printer

(This item would be moved to supplies as it is less than \$500.00).

CORRECT EXAMPLES

Pentium 4 Processor 2.8 Hz., 800 MHz FBS, 512 MB RAM, 32 MB RAM PCI, 40 GB EIDE 7200RPM, 1.44 MB 3.5 in. floppy drive
Fat Ethernet 100 Mbps, EIDE CD ROM drive48X, Sound Blaster, Business Audio Speakers, PS/2 Keyboard, PS/2 2-Button Mouse,
Windows XP Professional with SP2, 17 inch SVGA color monitor .28 mm, support 1024x768 resolution, 3 yr ltd Warranty. 1 @ \$1,500
24" Zenith Portable TV/VCR Combination;

Model #Z12345

1 @ \$750

Form I - 3 Minimum Computer Specifications Form

The following table contains minimum computer equipment specifications required for computer equipment purchases approved by the Department of State Health Services. Please see notes on the next page for additional requirements.

Minimum Computer Equipment Specifications (03/01/2009)	
Processor	Intel Dual Core Processor – 2.0 GHz or higher or AMD Athlon 64 X2 Processor – 2.0 GHz or higher
Memory	2 GB RAM, 800 MHz or higher
Video Card	256 MB RAM PCI Express or AGP or higher
Hard Drives	80 GB SATA 7200RPM or higher
USB Ports	Four USB 2.0 Ports or higher
Network Adapter (NIC)	Fast Ethernet 100 Mbps or higher
CDROM	SATA CD ROM drive (52X speed or higher) or higher
Audio Solutions	Sound Blaster Compatible
Speakers	Business Audio Speakers or higher
Keyboards	USB Keyboard
Mouse:	2-Button USB Optical Scroll Mouse or higher
Operating System	Windows® XP Professional (SP2 or newer*)
Monitor:	17 inch Color LCD Monitor VGA or DVI or higher (optional)
Security	Antivirus and Anti-Spyware Software
Hardware Support Services	4Yr Ltd NBD Warranty On-Site Service or higher

* Operating systems must be Professional or Business Editions

Notes:

- a.) A complete system price shall not exceed \$1,500.00 for a desktop/laptop system. Please submit justification when the purchase cost for a system exceeds these limits.
- b.) When contractor budgets are prepared to purchase computer equipment, complete computer equipment specifications, including printers, must be submitted to DSHS.
- c.) Vendors who assemble systems with generic (clone) computer parts or upgrade components must complete and submit the attached vendor certification to the quote and equipment specifications the vendor presents to
- d.) Due to market volatility, the pricing of computer equipment or peripherals may fluctuate greatly within weeks. The DSHS considers vendor quotations issued greater than 30 days from the current date to be expired

If you need additional information, please contact *Austin Metro Branch Manager, Information Technology Section, 512-458-7271*

Vendor Certification for Computer Equipment purchased by DSHS Contractor

(Please attach to Vendor's computer equipment quote and specifications.)

- 1.) All equipment components shall be new at time of purchase, of current production, and shall include the manufacturer's standard equipment, accessories (power cords, cables, etc.) and component documentation.
- 2.) All equipment components shall be one hundred percent (100%) IBM-compatible microcomputers, capable of running the same software, and capable of operating with add-on/options cards designed to run in IBM-compatible microcomputers.
- 3.) All equipment shall be certified 100% compatible with Microsoft Windows 2003 or higher. All equipment purchased for use as network file servers shall be Microsoft/National Software Testing Laboratories-certified to operate Windows 2003 Advanced Server or higher and Novell-certified to operate as a Netware 6.5 server or higher.
- 4.) DSHS is aware problems may develop in computer equipment due to heat generated by the components. The vendor must certify its computer system is designed in such a manner to allow for adequate heat dissipation and the vendor shall repair, replace, or add additional components to systems which have problems which are determined to be heat-related.
- 5.) DSHS expects systems and equipment purchased by DSHS contractors will be quality merchandise. Further, we expect the equipment will operate properly at the time of initial installation. DSHS hereby establishes and defines Excessive Failure as a failure rate greater than one percent (1%) of the items specified and provided to a DSHS contractor by the vendor which becomes non-operational and/or unusable during the course of normal operation. All problems must be repaired or replaced at the vendor's expense, including parts, labor, and any necessary freight or handling charges. If the vendor does not repair and/or replace the defective system(s)/component(s) within twenty-four (24) business hours of notification, the DSHS and/or its contractor shall have the right to take whatever reasonable actions are necessary to repair and/or replace the defective system(s)/components(s), and shall have the right to recover from the vendor all expenses incurred from these actions. Intentional or accidental damage of any system(s) and/or component(s) caused by employees and/or clients and/or acts of nature to the equipment shall not be construed as failure for the purpose

Authorized Vendor Signature: _____

Date: _____

Printed Name: _____

Title: _____

Company Name: _____

Phone: _____

Company Address: _____

City

State

Zip

FORM I-4: SUPPLIES Budget Category Instructions

DEFINITION: Supplies are defined as consumable items necessary to carry out the services under this DSHS project including medical supplies, drugs, office supplies, patient educational supplies, software, and any items of tangible personal property other than those defined as equipment on Form I-3 - Equipment and Controlled Assets.

INSTRUCTIONS - Enter the following information:

Description of Item - provide a detail description of the supply item, including quantity if applicable;

Purpose & Justification - state why the supplies are necessary and how they will be used in carrying out the DSHS project;

Total Cost - enter the total cost of each supply line item.

FORM I-5: CONTRACTUAL Budget Category Instructions

DEFINITION: The costs of activities directly associated with carrying out the statement of work that are contracted by the organization to a third party are recorded in the "Contractual" category. A contract with a subrecipient must comply with Article XII, section titled "Contracts with Subrecipient Subcontractors" of the DSHS General Provisions. The contractor may enter into contracts with subrecipient subcontractors unless restricted or otherwise prohibited in a specific Program Attachment(s). Prior to entering into an agreement equaling \$100,000 or more of a Program Attachment amount, Contractor shall obtain written approval from DSHS. Contracts with subcontractors shall be in writing and include the following:

Name and address of all parties;

A detailed description of the services to be provided;

Measurable method and rate of payment and total amount of contract;

Clearly defined and executable termination clause;

Beginning and ending dates that coincide with the dates of the applicable Program Attachment(s) or cover a term within the beginning and ending dates of the applicable Program Attachment(s);

Access to inspect the work and the premises on which any work is performed, in accordance with the General Provisions;

and a copy of these General Provisions and a copy of the Statement of Work and any Special Provisions in the Program Attachment(s) applicable to the subcontract.

Contractor is responsible to DSHS for the performance of any subcontractor. Contractor shall monitor both financial and programmatic performance and maintain pertinent records that shall be available for inspection by DSHS. Contractor shall ensure that subcontractors are fully aware of the requirements placed upon them by state/federal statutes and regulations and under this Contract. Contractor shall not contract with a subcontractor, at any tier, that is debarred or suspended or excluded from or ineligible for participation in federal assistance programs. **When subcontracting, Contractor is required to meet all applicable HUB requirements.**

INSTRUCTIONS - enter the following information:

Contractor Name - names of the individuals or organizations performing the services;

Description of Service - a description of the services being contracted;

Justification - justification should include why respondent needs to contract for the service, why the service is necessary to perform the scope of work and how the respondent will ensure that the cost of the service is reasonable;

Method of Payment - the method of reimbursement (cost reimbursement or unit cost);

of Hours or Units of Service - the number of hours or units of service to be purchased;

Hourly/Unit Rate - the hourly/unit cost if applicable;

Total - total amount of each subcontract.

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 the CONTRACTUAL Budget Category Detail Form.

FORM I-5: CONTRACTUAL Budget Category Detail Form Example

Legal Name of Respondent: Apple County Health Department

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
Dr. Bob Gilly, D. O.	Oversees medical services.	Medical director required by DSHS.	Monthly	12	\$300.00	\$3,600
Dr. James Paul, D. O.	Provides health history & physicals.	Contract physician at clinics performing medical exams.	Hourly	1560	\$23.34	\$36,408
Dr. Billy Bode, D. O.	Provides professional guidance.	Medical Consultant	Cost Reimbursement	1	\$1,200.00	\$1,200

Total Amount Requested for CONTRACTUAL: \$41,208

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent:

Collin County Health Care Services

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 cost. 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)
Envision	Chest x-rays	Needed for TB patients (DSHS Funding)	Monthly	12	\$867.17
Jerry Barnett	Pharmacist	Needed for TB patients (DSHS Funding)	Monthly	12	\$200.00

Total Amount Requested for CONTRACTUAL:

FORM I-6: OTHER Budget Category Instructions

DEFINITION: All other allowable direct costs not listed in any of the above categories are to be included in the "Other" category. Some of the costs listed below may also be treated as indirect cost. Their treatment as "Other" (direct) or indirect must be consistent throughout the respondent's organization. Typical costs that may be budgeted in the "Other" category are the approved DSHS program attachment's share of:

- * equipment rental if used solely on the DSHS project, otherwise include in "Indirect Costs" ;
- * single audit services if allocated directly to each funding source, otherwise include in "Indirect Costs";
- * long distance telephone expenses, (general telephone expenses should be included in "Indirect Costs");
- * printing and reproduction expenses directly related to the DSHS project;
- * postage and shipping directly related to the DSHS project;
- * contract personnel services for individuals that work solely on activities described in the DSHS Statement of Work;
- * equipment repairs or service maintenance agreements for equipment used solely on the DSHS funded project;
- * periodicals;
- * advertising that promotes the DSHS project;
- * registration fees;
- * patient transportation;
- * training costs, speakers fees and stipends.

INSTRUCTIONS: Enter the following information:

Description of Item - a general description of the goods/service, include quantity if applicable;

Purpose & Justification -the justification should include an explanation of the purpose of the goods/service and why it is necessary for the completion of the activity;

Total Cost - the total cost should only include the cost of goods that will be consumed during the contract term and services that will be utilized during the contract term.

FORM I - 7 Indirect Costs, Example and Instructions

Legal Name of Respondent:

Apple County Health Department

Total amount of indirect costs allocable to the project:

Amount **\$3,575**

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: 8.750%

BASE: 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.

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 attached to Form I - 7. If a rate agreement is pending, submit the latest approved agreement.

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: 10.25%

TYPE: (central service or indirect)

BASE: Direct Salary and Wages

Note: Governmental entities 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.

INSTRUCTIONS: OMB Circular A-87 permits States, Local and Indian Tribal Governments to prepare central service and indirect cost rate proposals in accordance with the requirements of the Circular and maintain the proposal and related supporting documentation for audit. The Circular goes on to state that no rate shall be acceptable unless such costs have been certified by the governmental unit using the Certificate of Cost Allocation Plan or Certificate of Indirect Costs as set forth in Attachments C and E. The certification forms are also available in the Appendix to the DSHS Contractor's Financial Procedures Manual (CFPM) available on the internet at: <http://www.dshs.state.tx.us/contracts/>

NOTE: Governmental entities must also submit a cost allocation plan as specified in Appendix A of the Contractor's Financial Procedures Manual to DSHS within 60 days of the contract start date. Governmental entities that only have a central service cost rate must also include the indirect costs of the governmental department. The allocation of indirect costs of the department 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/>

If using a central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate: Salary/expenses of executive office staff (CEO, CFO), accounting office, personnel office; depreciation; facility maintenance; utility costs; general liability and property insurance;

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:

Facility costs, depreciation, utilities, and property insurance costs are captured in a separate cost center and allocated to cost objectives based on square footage occupied by the cost objective.

General administrative office, executive office, accounting office, and human resource office costs are captured in separate cost centers established for each office; the costs are pooled and allocated to benefited cost objectives based on direct salary/wages.

General organization costs (i.e. general liability insurance) are captured in a separate cost center and allocated to all cost objectives of the organization based on direct salary/wages.

FORM I - 7 Indirect Costs

Legal Name of Respondent:

Collin County Health Care Services

Total amount of indirect costs allocable to the project:

Amount:

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)

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:**