TEXAS Department of State Health Services

FY 2015 Local Public Health Services

FORM A - FACE PAGE

RESPONDENT INFORMATION

1) LEGAL NAME: COLLIN COUNTY HEALTH CARE SERVICES

2) MAILING Address Information (include mailing address, street, city, county, state and zip code):

Collin County Health Care Services
825 N. McDonald Street, Suite 145
McKinney, TX 75069

3) PAYEE Mailing Address (if different from above):

Collin County Auditor's Office
2300 Bloomdale Road, Suite 3100
McKinney, TX 75071

4) Federal Tax ID No. (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or if an individual, **Social Security Number** (9 digit) : 756000873

*The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.

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

- ☐ City
- ☒ Regions/Counties/LHD
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith-based Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

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

6) COUNTIES OR REGION SERVED BY PROJECT: **COLLIN**
See attached County/Region list.

7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: PATSY MORRIS Phone: 972-548-5503 Fax: 972-548-5550 E-mail: pmorris@co.collin.tx.us	• **LPHS** $ 21,639.00

The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications attached in **FORM E,** and will provide services in accordance with **25 Texas Administrative Code, §§37.51-37.65.** 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.

8) AUTHORIZED REPRESENTATIVE	
Name: KEITH SELF Title: County Judge Phone: 972-548-4635 Fax: 972-548-4699 E-mail: Keith.self@co.collin.tx.us	**9) DATE : May 14, 2014** Keith Self

FY 2015 Local Public Health Services

Division for Regional and Local Health Services

Program Contact Information

Contract Term: September 1, 2014 through August 31, 2015

Legal Name of Applicant: COLLIN COUNTY HEALTH CARE SERVICES

This form provides information about appropriate program contacts in the applicant's organization. If any of the contact information changes during the term of the contract, please send written notification to the Regional and Local Health Service & Compliance Branch, Mail Code 1990, P.O. Box 149347, Austin, Tx 78714 or email to ***LocalPHTeam@dshs.state.tx.us*** .

Director

Contact:	CANDY BLAIR	**Mailing Address (street, city, county, state, & zip):**
Title:	ADMINISTRATOR	825 N. McDonald Street, Suite 145
Phone:	972-548-5504	MCKINNEY
Fax:	972-548-5550	COLLIN COUNTY
E-mail:	cblair@co.collin.tx.us	TEXAS 75069

Financial Manager

Contact:	JANNA BENSON-CAPONERA	**Mailing Address (street, city, county, state, & zip):**
Title:	AUDITOR'S OFFICE	2300 BLOOMDALE ROAD, SUITE 3100
Phone:	972-548-4638	MCKINNEY
Fax:	972-548-4643	COLLIN COUNTY
E-mail:	jbenson-caponera@co.collin.tx.us	TEXAS 75071

Contract Coordinator

Contact:	PATSY MORRIS	**Mailing Address (street, city, county, state, & zip):**
Title:	HC COORDINATOR	825 N. McDonald, Suite 145
Phone:	972-548-5503	MCKINNEY
Fax:	972-548-5550	COLLIN COUNTY
E-mail:	pmorris@co.collin.tx.us	TEXAS 75069

Additional Staff

Contact:	EILEEN PRENTICE	**Mailing Address (street, city, county, state, & zip):**
Title:	AUDITOR'S OFFICE	2300 BLOOMDALE RD., SUITE 3100
Phone:	972-548-4796	MCKINNEY
Fax:	972-548-4751	COLLIN COUNTY
E-mail:	eprentice@co.collin.tx.us	TEXAS 75071

Additional Staff

Contact:		**Mailing Address (street, city, county, state, & zip):**
Title:		
Phone:		
Fax:		
E-mail:		

EXHIBIT A

FY 2015 Request for Local Public Health Services Funds
Project Service Delivery Plan

Texas Department of State Health Services

Local Health Department: COLLIN COUNTY HEALTH CARE SVCS

Contract Term: September 1, 2014 through August 31, 2015

Indicate in this plan how requested Local Public Health Services (LPHS) contract funds will be used to address a public health issue through essential public health services. The plan should include a brief description of the public health issue(s) or public health program to be addressed by LPHS funded staff, and measurable objective(s) and activities for addressing the issue. List only public health issues/programs, objectives and activities conducted and supported by LPHS funded staff. List at least one objective and subsequent required information for each public health issue or public health program that will be addressed with these contract funds. The plan must also describe a clear method for evaluating the services that will be provided, including identification of a specific evaluation standard, as well as recommendations or plans for improving essential public health services delivery based on the results of the evaluation. Complete the table below for each public health issue or public health program addressed by LPHS funded staff. (Make additional copies of the table as needed)

Public Health Issue: ***Briefly describe the public health issue to be addressed. Number issues if more than one issue will be addressed.*** **TB – There has been a significant increase in the number of TB cases over the past few years which has caused an increase in DOT services.**		
Essential Public Health Service(s): ***List the EPHS(s) that will be provided or supported with LPHS Contract funds*** **EPHS#2 Diagnose and investigate community health hazards.**		
Objective(s): ***List at least one measurable objective to be achieved with resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc.)*** **Offer patient therapy within the clinic as well as DOT to all active TB cases and LTBIs.**		
Performance Measure: ***List the performance measure that will be used to determine if the objective has been met. List a performance measure for each objective listed above.*** ***Report will reflect all cases reported as well as treatment received and/or offered for LTBIs.***		
Activities ***List the activities conducted to meet the proposed objective. Use numbering system to designate match between issues/programs and objectives.***	**Evaluation and Improvement Plan** ***List the standard and describe how it is used to evaluate the activities conducted. This can be a local, state or federal guideline.***	**Deliverable** ***Describe the tangible evidence that the activity was completed.***
Provide drug therapy to all active TB cases and LTBIs.		

The following **EXAMPLE** of a Service Delivery Plan is offered as a guide for completing the table to address your specific public health issue(s).

Public Health Issue: ***Briefly describe the public health issue to be addressed. Number issues if more than one issue will be addressed.***

The local community lacks an accurate assessment of the local public health system in order to strategically plan and improve the essential public health services provided in the community.

Essential Public Health Service(s): ***List the EPHS(s) that will be provided or supported with LPHS Contract funds***

EPHS (9) Evaluate effectiveness, accessibility and quality of personal and population-based health services.

Objective(s): ***List at least one measurable objective to be achieved with resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc.)***

Objective 1.1 By the end of the 2nd quarter FY13, all LHD's funded through LPHS Contract dollars, will have conducted the CDC National Public Health Performance Standards Local Public Health System Performance Assessment Instrument (LPHSPAI).

Performance Measure: ***List the performance measure that will be used to determine if the objective has been met. List a performance measure for each objective listed above.***

Performance Measure – Based on LPHSPAI results, local health departments will submit a draft Service Delivery Plan to be completed by end of 3rd Quarter FY14.

Activities *List the activities conducted to meet the proposed objective. Use numbering system to designate match between issues/programs and objectives.*	**Evaluation and Improvement Plan** *List the standard and describe how it is used to evaluate the activities conducted.*	**Deliverable** *Describe the tangible evidence that the activity was completed.*
1.1.1 Participate in training offered by the state. 1.1.2 Identify necessary partners who will take part in conducting the LPHSPAI instrument. 1.1.3 Conduct LPHSPAI with identified partners. 1.1.4 Submit LPHSPAI data to the CDC for processing. 1.1.5 Gather CDC generated report on local assessment.	1.1.1 LHD's will plan and implement the LPHSPAI instrument in the designated communities no later than March 31st, 2013. 1.1.2 LPHSPAI results will be incorporated into the FY14 Service Delivery Plans.	1.1.1 LPHSPAI data analysis report will be obtained from CDC.

Texas Department of State Health Services
FY 2015 Local Public Health Services Funds
Project Service Delivery Plan
Quarterly and Final Performance Report

Local Health Department:	**Contact:**	**Contact Phone:**
Address: ***Include City, State, Zip***		
Contact Email:		**Date:**

Quarterly reports must be completed and submitted by the dates shown below. Complete the report table by providing the status of contract activities, identifying barriers to completing the activities, and listing deliverables. This report form should be completed cumulatively (each quarter's report added on to the previous report) and submitted to the Contract Manager, Regional and Local Health Services & Compliance Branch at: LocalPHTeam@dshs.state.tx.us. For technical assistance or questions contact the Contract Manager at (512)776-2181, or email at LocalPHTeam@dshs.state.tx.us. Please note that the **4th Quarter Report** must also include the **Final Report** with information to document results from the evaluation of services and a plan for improving the services.

*This report is designed to **"tab"** through the items to complete all of the sections. Indicate the reporting Quarter by clicking on the appropriate gray box.*

	Reporting Periods	**Report Due Date**
☐ **1st Quarter**	**September 1st thru November 30th**	**December 31st**
☐ **2nd Quarter**	**December 1st thru February 28th**	**March 31st**
☐ **3rd Quarter**	**March 1st thru May 31st**	**June 30th**
☐ **4th Quarter/Final Report**	**June 1st thru August 31st (Qtr)/September 1st thru August 31st (Final)**	**September 30th**

Public Health Issue(s): ***Briefly describe the public health issue to be addressed. Number issues if more than one issue is addressed.***

Objective(s): ***List the measurable objective(s) to be achieved by using resources funded through this contract. Number all objectives to match issue being addressed. Ex: 1.1, 1.2, 2.1, 2.2, etc)***

Local Health Department:

	Activity – *list each activity conducted to meet the objective. Use numbering system to designate match with objectives and issues.*	**Status of Activity** ***Provide status of each activity for the reporting quarter***	**Barriers to conducting activities:** ***List any problems or barriers encountered that impact your ability to conduct or complete the activity***	**Deliverables:** ***List the deliverable that provides tangible evidence that the activity was completed (4th quarter only)***

Q1				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Beginning with the Q2 report, incorporate improvement activities listed in the Project Service Delivery Plan. Please specify if these improvement activities will replace or amend any of the activities listed in the Q1 Report.				
Q2				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Q3				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			
Q4				
Success Stories *Optional*	**Briefly describe a LHD success story highlighting an event or situation that occurred resulting from efforts funded through LPHS Contract funds.**			

Texas Department of State Health Services
FY 2015 Local Public Health Services Funds
Project Service Delivery Plan
Quarterly and Final Performance Report

FINAL REPORT		
Local Health Department:		
The information requested below should be completed and submitted* ONLY *with the 4th Quarter's report after the project period is completed. Duplicate the table below as needed for each objective listed in the FY 2015 Service Delivery Plan.		
Objective: ***List each objective outlined in the Service Delivery Plan.***	**Status:** ***Document whether or not the objective was achieved***	**Comments:** ***Provide an explanation if objective was not met***

Evaluation Results and Improvement Plan: *Describe the findings from the evaluation of project. List activities that will be conducted during the next contract term to improve the essential public health services or meet the objective. Also, include a plan for improving or amending activities for objectives that were not met during this contract term.*

Evaluation Standard:

Evaluation Activities:

Results/Findings:

Improvement Plan:

NOTICE

Refer to 2nd Excel file via email for DSHS Categorical Budget Forms

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
A. Personnel	$599,107	$16,803	$80,011	$119,975	$382,318	$0
B. Fringe Benefits	$168,814	$4,836	$22,403	$33,593	$107,982	$0
C. Travel	$1,084	$0	$804	$280	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$4,548	$0	$602	$3,946	$0	$0
F. Contractual	$18,202	$0	$15,802	$2,400	$0	$0
G. Other	$0	$0	$0	$0	$0	$0
H. Total Direct Costs	$791,755	$21,639	$119,622	$160,194	$490,300	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$791,755	$21,639	$119,622	$160,194	$490,300	$0
K. Program Income - Projected Earnings	$0	$0	$0	$0	$0	

NOTE: The "Total Budget" amount for each Budget Category will have to be allocated (entered) manually among the funding sources. Enter amounts in whole dollars. After amounts have been entered for each funding source, verify that the "Distribution Total" below equals the respective amount under the "Total Budget" from column (1).

	Budget Catetory	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	**Personnel**	**$599,107**	**$599,107**	**Fringe Benefits**	**$168,814**	**$168,814**
	Travel	**$1,084**	**$1,084**	**Equipment**	**$0**	**$0**
	Supplies	**$4,548**	**$4,548**	**Contractual**	**$18,202**	**$18,202**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$791,755**	**Budget Total**	**$791,755**

*Letter(s) of good standing that validate the respondent's programmatic, administrative, and financial capability must be placed after this form if respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include funding from other state agencies in column 4 or Federal sources in column 3 that is not related to activities being funded by this DSHS project.

FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

PERSONNEL Functional Title + Code E = Existing or P = Proposed	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Program Manager - RN - E	N	Provides programmatic oversight and programmatic accountability	0.25	License	$5,601.00	12	$16,803
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$16,803

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

FICA/Medicare: 7.65%; Employee Insurance: $800 monthly per employee; long-term disability: .25%; short-term disability: $1.91; long-term care based on employee election; retirement: 8.5%; Supplemental Death benefit: .3%; Unemployment Insurance: .1%

Fringe Benefit Rate %	28.78%
Fringe Benefits Total	$4,836

Revised: 7/6/2009

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: Days/Employees	Travel Costs	
None				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $0

Revised: 7/6/2009

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
			$0		$0
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					$0

Total for Other / Local Travel $0

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

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

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category

Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

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

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
None				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
				$0
	TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS			$0

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

Revised: 7/6/2009

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

Itemize and describe each supply item and **provide an estimated quantity and cost (i.e. #of boxes & cost/box) if applicable.** Provide a justification for each supply item. Costs may be categorized by each general type (e.g., office, computer, medical, educational, etc.) See attached example for definition of supplies and detailed instructions to complete this form.

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	**Purpose & Justification**	**Total Cost**
None		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

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

Revised: 7/6/2009

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 co 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)
None					
			TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS		

Total Amount Requested for CONTRACTUAL:

ntractors as "To Be

TOTAL
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0

$0

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	**Purpose & Justification**	**Total Cost**
None		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
		$0
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

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

FORM I - 7 Indirect Costs

Legal Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

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

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

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

RATE:
BASE:

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

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.

RATE:
TYPE:
BASE:

_____ 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:**