Inter-Local Application For Tuberculosis Prevention and Control for FY 2018 State Funds

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

TB Services Branch

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

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

RESPONDENT INFORMATION

1) LEGAL BUSINESS NAME: Collin County Health Care Services

2) MAILING Address Information (include mailing address, street, city, county, state and 9-digit zip code): **Check if address change** ☐

825 N. McDonald St., Suite 130, McKinney, TX 75069

3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above): **Check if address change** ☐

Collin County Auditor's Office, 2300 Bloomdale Road, Suite 3100, McKinney, TX 75070

4) DUNS Number (9-digit) required if receiving federal funds: N/A

5) Federal Tax ID No. (9-digit), **State of Texas Comptroller Vendor ID Number** (14-digit) or **Social Security Number** (9-digit): 756000873

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

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

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

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

7) PROPOSED BUDGET PERIOD: **Start Date:** 09/01/2017 **End Date:** 08/31/2018

8) COUNTIES SERVED BY PROJECT:

Collin

9) AMOUNT OF FUNDING REQUESTED: $152,828

10) PROJECTED EXPENDITURES

Does respondent's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for respondent's current fiscal year (excluding amount requested in line 9 above)? **

Yes ☐ No ☒

***Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.*

11) PROJECT CONTACT PERSON

Name: Joann Gilbride
Phone: 972-548-5503
Fax: 972-548-4441
Email: jgilbride@co.collin.tx.us

12) FINANCIAL OFFICER

Name: Jeff May
Phone: 972-548-4641
Fax: 972-548-4696
Email: countyauditor@co.collin.tx.us

The facts affirmed by me in this proposal are truthful and I warrant the respondent is in compliance with the assurances and certifications contained in **APPENDIX B: DSHS Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the respondent and I (the person signing below) am authorized to represent the respondent.

13) AUTHORIZED REPRESENTATIVE **Check if change** ☐

Name: KEITH SELF
Title: COUNTY JUDGE
Phone: 972-548-4635
Fax: 972-548-4699
Email: 972-548-4699

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE Keith Self

15) DATE 2/13/17

FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the respondent and the proposed project with the Department of State Health Services (DSHS), including the signature of the authorized representative. It is the cover page of the proposal and is required to be completed. Signature affirms the facts contained in the respondent's response are truthful and the respondent is in compliance with the assurances and certifications contained in APPENDIX B: DSHS Assurances and Certifications and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below to complete the face page form and return with the respondent's proposal.

1) LEGAL BUSINESS NAME - Enter the legal name of the respondent.

2) MAILING ADDRESS INFORMATION - Enter the respondent's complete physical address and mailing address, city, county, state, and 9-digit zip code.

3) PAYEE NAME AND MAILING ADDRESS - Payee – Entity involved in a contractual relationship with respondent to receive payment for services rendered by respondent and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address, including 9-digit zip code, if PAYEE is different from the respondent. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) DUNS Number – 9- digit Dun and Bradstreet Data Universal Numbering System (DUNS) number. . This number is required if receiving ANY federal funds and can be obtained at: http://fedgov.dnb.com/webform

5) FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER - Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The respondent acknowledges, understands and agrees the respondent's choice to use a social security number as its vendor identification number for the contract, may result in the social security number being made public via state open records requests.

6) TYPE OF ENTITY - Check the type of entity as defined by the Secretary of State at http://www.sos.state.tx.us/corp/businessstructure.shtml and/or the Texas State Comptroller at https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf and check all other boxes that describe the entity.

   Historically Underutilized Business: A minority or women-owned business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. (http://www.window.state.tx.us/procurement/prog/hub/)
   State Agency: an agency of the State of Texas as defined in Texas Government Code §2056.001.ii
   Institutions of higher education as defined by §61.003 of the Education Code.
   MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.
   If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

7) PROPOSED BUDGET PERIOD - Enter the budget period for this proposal. Budget period is defined in the RFP.

8) COUNTIES SERVED BY PROJECT - Enter the proposed counties served by the project.

9) AMOUNT OF FUNDING REQUESTED - Enter the amount of funding requested from DSHS for proposed project activities (not including possible renewals). This amount must match column (1) row K from the BUDGET SUMMARY used for cost reimbursement budgets.

10) PROJECTED EXPENDITURES - If respondent's projected federal expenditures exceed $500,000 or its projected state expenditures exceed $500,000 for respondent's current fiscal year, respondent must arrange for a financial compliance audit (Single Audit).

11) PROJECT CONTACT PERSON - Enter the name, phone, fax, and email address of the person responsible for the proposed project.

12) FINANCIAL OFFICER - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.

13) AUTHORIZED REPRESENTATIVE - Enter the name, title, phone, fax, and email address of the person authorized to represent the respondent. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE - The person authorized to represent the respondent must sign in this blank.

15) DATE - Enter the date the authorized representative signed this form.

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

FORM C: CONTACT PERSON INFORMATION

Legal Business Name of Contractor: COLLIN COUNTY HEALTH CARE SERVICES

This form provides information about the appropriate contacts in the contractor'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 Contract Management Unit.

Contact:	CANDY BLAIR	Mailing Address (incl. street, city, county, state, & zip):
Title:	CCHCS ADMINISTRATOR	825 N. MCDONALD #130
Phone:	972-548-5504	MCKINNEY
Fax:	972-548-4441	COLLIN COUNTY
E-mail:	CBLAIR@CO.COLLIN.TX.US	TEXAS, 75069

Contact:	JOANN GILBRIDE	Mailing Address (incl. street, city, county, state, & zip):
Title:	HEALTHCARE COORDINATOR	825 N. MCDONALD #130
Phone:	972-548-5503	MCKINNEY
Fax:	972-548-4441	COLLIN COUNTY
E-mail:	JGILBRIDE@CO.COLLIN.TX.US	TEXAS, 75069

Contact:	EILEEN PRENTICE	Mailing Address (incl. street, city, county, state, & zip):
Title:	GRANT ACCOUNTANT	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

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.

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)	
Contract Number	Grant
2016-001394-00; 01	TB State Contract
2016-001388-00; 01	TB Federal Contract
2016-003785-00; 01	IDCU SUR Contract
2016-003819-00	IDCU SUR EB Contract
2016-001289-00	RLSS/LPHS Contract

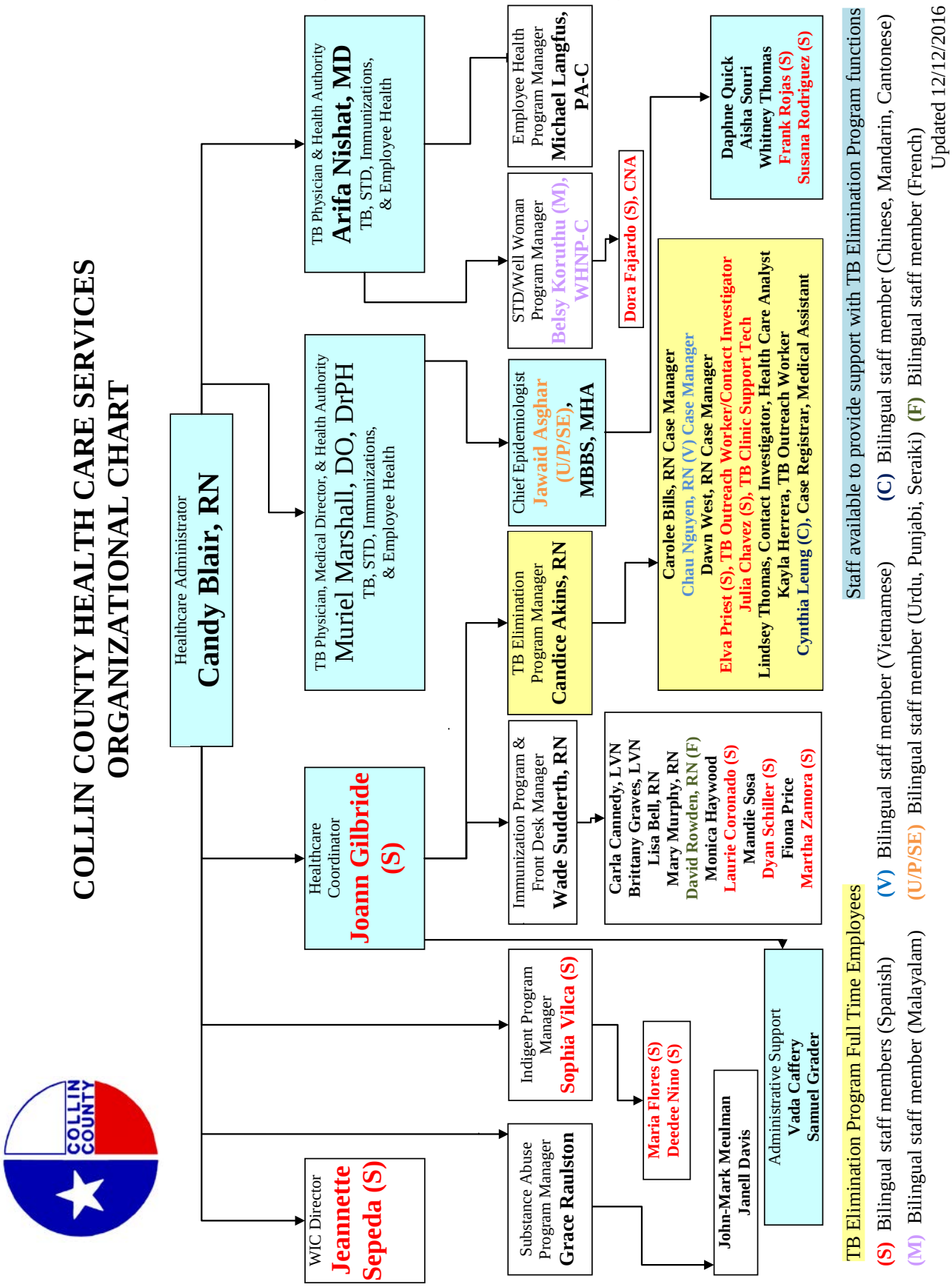
If NO, applicant must be able to demonstrate fiscal solvency. Submit a copy of the organization's most recently audited balance sheet, statement of income and expenses and accompanying financial footnotes DSHS will evaluate the documents that are submitted and may, at its sole discretion, reject the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


COLLIN COUNTY HEALTH CARE SERVICES
ORGANIZATIONAL CHART
Healthcare Administrator
Candy Blair, RN
TB Physician & Health Authority
Arifa Nishat, MD
TB, STD, Immunizations, & Employee Health
Employee Health Program Manager
Michael Langfus, PA-C
TB Physician, Medical Director, & Health Authority
Muriel Marshall, DO, DrPH
TB, STD, Immunizations, & Employee Health
STD/Well Woman Program Manager
Belsy Koruthu (M), WHNP-C
Chief Epidemiologist
Jawaid Asghar (U/P/SE), MBBS, MHA
Dora Fajardo (S), CNA
Healthcare Coordinator
Joann Gilbride (S)
Immunization Program & Front Desk Manager
Wade Sudderth, RN
TB Elimination Program Manager
Candice Akins, RN
Carla Cannedy, LVN
Brittany Graves, LVN
Lisa Bell, RN
Mary Murphy, RN
David Rowden, RN (F)
Monica Haywood
Laurie Coronado (S)
Mandie Sosa
Dyan Schiller (S)
Fiona Price
Martha Zamora (S)
Carolee Bills, RN Case Manager
Chau Nguyen, RN (V) Case Manager
Dawn West, RN Case Manager
Elva Priest (S), TB Outreach Worker/Contact Investigator
Julia Chavez (S), TB Clinic Support Tech
Lindsey Thomas, Contact Investigator, Health Care Analyst
Kayla Herrera, TB Outreach Worker
Cynthia Leung (C), Case Registrar, Medical Assistant
Daphne Quick
Aisha Souri
Whitney Thomas
Frank Rojas (S)
Susana Rodriguez (S)
WIC Director
Jeannette Sepeda (S)
Substance Abuse Program Manager
Grace Raulston
Indigent Program Manager
Sophia Vilca (S)
Maria Flores (S)
Deedee Nino (S)
John-Mark Meulman
Janell Davis
Administrative Support
Vada Caffery
Samuel Grader
Staff available to provide support with TB Elimination Program functions
TB Elimination Program Full Time Employees
(S) Bilingual staff members (Spanish)
(V) Bilingual staff member (Vietnamese)
(C) Bilingual staff member (Chinese, Mandarin, Cantonese)
(M) Bilingual staff member (Malayalam)
(U/P/SE) Bilingual staff member (Urdu, Punjabi, Seraiki)
(F) Bilingual staff member (French)
Updated 12/12/2016

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. For FY18 reporting, data will be drawn from calendar year 2017 (1/1/2017 -12/31/2017). A compliance percentage of not less than 85.3% is required. If fewer than 85.3% of newly reported TB cases have a result of an HIV test reported, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.

2. Cases, and suspected cases, of TB under treatment by Contractor shall be placed on timely and appropriate Directly Observed Therapy (DOT).
   For FY18 reporting, data will cover all cases from calendar year 2017 (1/1/2017 -12/31/2017). A compliance percentage of not less than 93.4% is required.
   If data indicates a compliance percentage for this Performance Measure of less than 93.4%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.

3. Newly-reported suspected cases of TB disease shall be started in timely manner on the recommended initial 4-drug regimen. For FY18 reporting, data will be drawn from calendar year 2017 (1/1/2017 - 12/31/2017). A compliance percentage of not less than 93.4% is required. If fewer than 93.5% of newly-reported TB cases are started on an initial 4-drug regimen in accordance with this requirement, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.

4. Newly-reported TB patients that are older than 12-years-old and that have a pleural or respiratory site of disease shall have sputum acid-fast bacilli (AFB)-culture results reported to DSHS according to the timelines for reporting initial and updated results given herein.
   For FY18 reporting, data will be drawn from calendar year 2017 (1/1/2017 -12/31/2017). A compliance percentage of not less than 93.5% is required.
   If data indicates a compliance percentage for this Performance Measure of less than 93.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.

5. Newly-reported cases of TB with AFB positive sputum culture results will have documented conversion to sputum culture-negative within 60 days of initiation of treatment. For FY18 reporting, data will be drawn from calendar year 2016(1/1/2016-12/31/2016). A compliance percentage of not less than 56% is required. If data indicates a compliance percentage for this Performance Measure of less than 56%, then DSHS may (at its sole discretion) require additional measures be taken by contractor to improve the percentage, on a timeline set by DSHS.
6. Newly diagnosed TB cases that are eligible* to complete treatment within 12 months shall complete therapy within 365 days or less.*Exclude TB cases 1) diagnosed at death, 2) who die during therapy, 3) who are resistant to Rifampin, 4) who have meningeal disease, and/or 5) who are younger than 15 years with either miliary disease or a positive blood culture for TB. For FY18 reporting, data will cover all cases from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 90.6% is required. If data indicates a compliance percentage for this Performance Measure of less than 90.6%,

then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.

7. Increase the proportion of culture-confirmed TB cases with a genotyping result reported. For FY18 reporting, data will be drawn from calendar year 2017 (1/1/2017 -12/31/2017). A compliance percentage of not less than 90.6 is required. If data indicates a compliance percentage for this Performance Measure of less than 90.6%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.
8. TB cases with initial cultures positive for Mycobacterium tuberculosis complex shall be tested for drug susceptibility and have those results documented in their medical record. For FY18 reporting, data will be drawn from calendar year 2017 (1/1/2017 -12/31/2017). A compliance percentage of not less than 98.0% is required. If data indicates a compliance percentage for this Performance Measure of less than 98.0%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.
9. Newly-reported TB patients with a positive AFB sputum-smear result shall have at least three contacts identified as part of the contact investigation that must be pursued for each case. For FY18 reporting, data will be drawn from calendar year 2017 (1/1/2017 -12/31/2017). A compliance percentage of not less than 96.0% is required. If data indicates a compliance percentage for this Performance Measure of less than 96.0%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.
10. Newly-identified contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive TB case shall be evaluated for TBI and disease. For FY18 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 88.0% is required. If data indicates a compliance percentage for this Performance Measure of less than 88.0%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.
11. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case and that are newly diagnosed with TBI shall be started on timely and appropriate treatment. For FY18 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 70% is required. If data indicates a compliance percentage for this Performance Measure of less than 70%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.
12. Contacts, identified through the contact investigation, that are associated with a sputum AFB smear-positive case that are newly diagnosed with TBI and that were started on treatment shall complete treatment for TBI as described in Targeted Tuberculin Testing and Treatment of Latent TB Infection (LTBI), Morbidity and Mortality Weekly Report, Vol. 49, No. RR-6, 2000; according to timelines given, therein. For FY18 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 64.0% is required. If data indicates a compliance percentage for this Performance Measure of less than 64.0%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.
13. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB, increase the proportion who initiate a medical evaluation within 30 days of arrival. Arrival is defined as the first notice or report; whether that is by fax, phone call, visit to the health department or EDN notification. For FY18 reporting, data will be drawn from calendar year 2017 (1/1/2017 -12/31/2017). A compliance percentage of not less than 63.5% is required. If data indicates a compliance percentage for this Performance Measure of less than 63.5%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.
14. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB, increase the proportion who initiate and complete a medical evaluation within 90 days of arrival. For FY18 reporting data will be drawn from calendar year 2017 (1/1/2017-12/31/2017). A compliance percentage of not less than 50.0% is required. If data indicates a compliance percentage for this Performance Measure of less than 60%, then DSHS may (at its sole discretion) require additional

measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.

15. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB and who are diagnosed with TBI during evaluation in the US, increase the proportion who start treatment. For FY18 reporting, data will be drawn from calendar year 2017 (1/1/2017 -12/31/2017). A compliance percentage of not less than 74.0% is required. If data indicates a compliance percentage for this Performance Measure of less than 74.0%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS.
16. For Class B immigrants and refugees with abnormal chest x-rays read overseas as consistent with TB and who are diagnosed with TB infection during evaluation in the US and started on treatment, increase the proportion who complete treatment for TB infection. For FY18 reporting, data will be drawn from calendar year 2016 (1/1/2016 -12/31/2016). A compliance percentage of not less than 59.0% is required. If data indicates a compliance percentage for this Performance Measure of less than 70%, then DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage, on a timeline set by DSHS

    If Contractor fails to meet any of the performance measures, Contractor shall furnish in the Annual Progress Report, due March 15, 2017, a written narrative explaining the barriers and the plan to address those barriers. This requirement does not excuse any violation of this Contract, nor does it limit DSHS as to any options available under the contract regarding breach
17. Transfer of 100% of collected TB case information, including but not limited to RVCTs, TB340, and TB341, to DSHS Program weekly by the close of business each Friday. Contractor may send a written request to DSHS Program to extend the timetable for transferring data, which must be received at least 24 hours in advance of the deadline at issue. Any such request shall be submitted by email.
18. Provide complete and legitimate information for the following seven (7) data elements for 100% of all submitted RVCT: 1)Date reported; 2)Legal name; 3)Date of birth; 4)Race and ethnicity; 5)Country of origin, if not U.S. Date of entry into U.S.; 5)Laboratory data necessary to meet case definition as applicable; 6)Count status and date counted; 7)Verification of Texas residency physical address, city, county, ZIP code with 4-digit code (and if in or outside city limits) If diagnosed while in a facility or shelter, provide facility or shelter name Initial drug susceptibility results, as applicable

    If data indicates that this requirement is being met less than ninety-eight-point-six percent (98.6%) of the time, DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage. In that scenario, Contractor must follow those additional measures, and do so according to the timetable mandated by DSHS.

19. Provide complete and legitimate information for the following ten (10) data elements to be reported on 100% of all reported individual contacts to sputum smear positive patients: 1)Name of linked case; 2)RVCT number of linked case; 3)Exposure length and setting; 4)HIV test results; 5)Priority status; 6)TST/IGRA test results 7)CXR date and interpretation; 8)Verification that a complete evaluation was performed. A complete evaluation for purposes of the contact aggregate report consists of a TST or IGRA result. If positive, a CXR date is required; 9)Diagnosis with an ATS classification (If prior positive TST or IGRA, or the possibility of the contact not returning for a chest x-ray, complete the DSHS TB-202 form for a Tuberculosis Health Assessment History or the equivalent thereof); 10)If evaluation was not performed, then provide a reason

    If data indicates that this requirement is being met less than one-hundred percent (100%) of the time, DSHS may (at its sole discretion) require additional measures be taken by Contractor to improve that percentage. In that scenario, Contractor must follow those additional measures, and do so according to the timetable mandated by DSHS.

Contractor shall maintain documentation used to calculate performance measures as required by General Provisions Article VIII "Records Retention" and by Texas Administrative Code Title 22, Part 9 Chapter 165, §165.1 regarding retention of medical records.

All reporting to DSHS shall be completed as described in Section I, "D. Reporting" and submitted by the deadlines given.

If Contractor fails to meet any of the performance measures, Contractor shall furnish in the Annual Progress Report, due March 15, 2016, a written narrative explaining the barriers and the plan to address those barriers. This requirement does not excuse any violation of this Contract, nor does it limit DSHS as to any options available under the contract regarding breach.

FORM I: BUDGET SUMMARY INSTRUCTIONS

DSHS Costs Only Budgeted on Detail Category Pages

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. **On each detail category budget form, budget only those costs that you plan to bill to DSHS.** The total amounts budgeted on each detail budget category form will be automatically posted to the respective budget category on "Form I - Budget Summary" under column # 2 "DSHS Funds Requested". The amounts budgeted on each detail budget MATCH category form will be automatically posted to the respective budget category on "Form I - Budget Summary" under column # 5 "Local Funding (Match)". 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.

Column 1: The total amount of funds budgeted from all funding sources for the DSHS project. The total of all funding sources (Columns 2 - 6) for each budget category will be automatically totaled. **Do not enter amounts in Column (1) except for the amount of Program Income.**

Columns 2 - 6: Enter the amount of funding to be provided by each funding source for each "Cost Category" in columns 3 - 6.

Column 2: DSHS funds requested. (automatically posted from each detail budget category form)
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) (MATCH)
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.

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/cfpm.shtm

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.*

Check Totals: Refer to the table below the budget template table to verify that the amounts distributed ("Distribution Total") in each budget category equals the "Budget Total" for each respective category. Next, verify that the overall total of all distributions (Distribution Totals) equals the Budget Total.

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 (Match) (5)	Other Funds **(6)**
A. Personnel	$714,817	$65,377	$69,463		$22,447	$557,530
B. Fringe Benefits	$257,386	$28,831	$20,075		$8,119	$200,361
C. Travel	$4,230	$1,728	$1,344		$0	$1,158
D. Equipment	$0	$0			$0	
E. Supplies	$19,276	$7,992	$11,284		$0	
F. Contractual	$52,400	$47,400	$5,000		$0	
G. Other	$8,720	$1,500	$7,220		$0	
H. Total Direct Costs	$1,056,829	$152,828	$114,386	$0	$30,566	$759,049
I. Indirect Costs	$0	$0			$0	
J. Total (Sum of H and I)	$1,056,829	$152,828	$114,386	$0	$30,566	$759,049
K. Program Income - Projected Earnings	$2,890	$405	$0	$0	$0	$2,485

NOTE: The "Total Budget" amount for each Budget Category will have to be populated among the funding sources. Enter amounts in whole dollars for (3), (4), & (6), *if applicable*. After amounts have been entered for each funding source, verify that the "Distribution Total" below equals the respective amount under the "Total Budget" from column (1).

	Budget Catetory	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	**Personnel**	**$714,817**	**$714,817**	**Fringe Benefits**	**$257,386**	**$257,386**
	Travel	**$4,230**	**$4,230**	**Equipment**	**$0**	**$0**
	Supplies	**$19,276**	**$19,276**	**Contractual**	**$52,400**	**$52,400**
	Other	**$8,720**	**$8,720**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$1,056,829**	**Budget Total**	**$1,056,829**

*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 Name + Functional Title E = Existing or P = Proposed	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
Chau Nguyen- Public Health Nurse-E	N	Provides direct TB services	0.36	License	$5,124.83	12	$22,139
Lindsey Thomas-Contact Investigator-E	N	Provides direct TB services	0.36	NA	$3,892.03	12	$16,814
Kayla Herrera-Outreach Worker-E	N	Provides direct TB services	0.36	NA	$3,285.36	12	$14,193
Julia Chavez-Medical Assistant-E	N	Provides direct TB services	0.36	Certification	$2,831.33	12	$12,231
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
				TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS			$0
					SalaryWage Total		$65,377

FRINGE BENEFITS	**Itemize the elements of fringe benefits in the space below:**	
FICA/Medicare: 7.65%; Employee Insurance: $1050 monthly per employee; long-term disability: .26%; short-term disability: $3.20; long-term care based on employee election; retirement: 8.5%; Supplemental Death benefit: .25%; Unemployment Insurance: .1%		
	Fringe Benefit Rate %	44.10%
	Fringe Benefits Total	$28,831

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	
DSHS Conference/Workshop/Training	TB Program Updates (Mileage-$.535/mile X140 miles, Airfare $200 per roundtrip flight per person, Meals-$35 per person per day + additional $5 per person in the event the federal per diem changes for 2018; $150 per night/per person lodging at hotel)	Austin	2 days/ 1 employees	Mileage	$75
				Airfare	$200
				Meals	$75
				Lodging	$300
				Other Costs	$0
				Total	$650
DSHS Conference/Workshop/Training	Contact Investigation or RN Case Manager Training (Mileage-$.535/mile X140 miles, Airfare $200 per roundtrip flight per person, Meals-$35 per person per day + additional $5 per person in the event the federal per diem changes for 2018; $150 per night/per person lodging at hotel)	Austin	2 days/ 1 employees	Mileage	$75
				Airfare	$200
				Meals	$75
				Lodging	$300
				Other Costs	$0
				Total	$650
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
				Mileage	$0
				Airfare	$0
				Meals	$0
				Lodging	$0
				Other Costs	$0
				Total	$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					$0

Total for Conference / Workshop Travel $1,300

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Home visits to TB patients, visits to providers office for TB education/presentations, site visits for contact investigations	800	$0.535	$428		$428
			$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 $428

Other / Local Travel Costs: $428 Conference / Workshop Travel Costs: $1,300 **Total Travel Costs:** $1,728

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/quote.

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: 1/27/2012

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
Medical Supplies - All supplies used in clinic for TB patients: blood draws for T-Spot testing, masks & sanitizer for TB protocol	Medical supplies used in TB clinic such as: (boxes of blood collection tubes @$55; Masks @$25.00/bx; hand sanitizer btls @ $6.50 ea; butterflies for drawing blood - cases @$60/per case	$2,868
Medical Supplies - all supplies used for TB patients for services and sanitizing. Need sharps to dispose of biohazard waste.	Antimicrobial Liq. Soap bottles @$9 ea.; Caviwipes Tub @$8 ea.; Diamond Grip Gloves Med.bxs @$10 bx.; Diamond Grip Gloves Lge-bxs @$10; Vacutainer Needle Holder bags @ $10 bg; Sharps containers @ $65/case; other medical supplies to treat and evaluate TB patients	$2,783
Medical Supplies - TB supplies necessary for the administration of PPDs and blood draws.	Curity Alcohol preps @$4 bx; Coverlet strip pieces @ $2 bx	$86
General Office Supplies	Pens for patients to fill out forms, self stick notes, highlighters, binders for charts, binder tabs, padded envelopes	$2,000
Reference Materials	TB reference books/education for providers and TB staff	$255
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Supplies: **$7,992**

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 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
Jerry Barnett	Pharmacist	Needed for TB patients' meds	Monthly	12	$200.00	$2,400
Oxford Immunotec	T-Spot lab testing	TB blood test	Unit	900	$50.00	$45,000
						$0
						$0
						$0
						$0
						$0
						$0
						$0
				TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS		$0

Total Amount Requested for CONTRACTUAL: $47,400

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
Language Line	Translation service for TB patients	$1,500
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for Other: **$1,500**

Revised: 1/27/2012

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

Legal Name of Respondent: **COLLIN COUNTY HEALTH CARE SERVICES**

PERSONNEL Name + Functional Title E = Existing or P = Proposed	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	**Number of Months**	Salary/Wages Requested for Project
Carolee Bills-Nurse E	N	Provides TB Services	0.37	License	$5,124.85	12	$22,447
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
					SalaryWage Total		$22,447

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

FICA/Medicare: 7.65%; Employee Insurance: $1050 monthly per employee; long-term disability: .26%; short-term disability: $3.20; long-term care based on employee election; retirement: 8.5%; Supplemental Death benefit: .25%; Unemployment Insurance: .1%

Fringe Benefit Rate %	36.17%
Fringe Benefits Total	$8,119