Joann Gilbride

From: Joann Gilbride
Sent: Thursday, February 07, 2019 5:48 PM
To: 'Paradise,Caeli (DSHS)'
Cc: Candy Blair; Samuel Grader; Eileen Prentice
Subject: RE: Collin County contract packet for IDCU/SUR
Attachments: Original Face Page FY2020 IDCU SUR 2 6 2019.docx; FY2020 FY2021 IDCU SUR Budget Template CCHCS 2 7 2019.xlsx

Follow Up Flag: Follow up
Flag Status: Flagged

Ms. Paradise,

Thank you for your time today to discuss our FY2020/FY2021 IDCU SUR grant contract. My understanding from our conversation is that the state is still awaiting final confirmation of the overall program funding so it may be some time before there is an answer on whether additional funding is available. For that reason, I am resubmitting our budget worksheet and face page as requested to reflect the current award amount of $342,445. The attached budget indicates each position being funded at less than (1) FTE in order to stay within the allocated award amount. Please let me know if you have any questions.

Thank you,

Joann L. Gilbride
Healthcare Coordinator
Collin County Health Care Services
825 N. McDonald #130
McKinney, TX 75069
P: 972-548-5503
F: 972-548-4441

From: Joann Gilbride
Sent: Wednesday, February 06, 2019 6:32 PM
To: 'Paradise,Caeli (DSHS)'
Cc: Candy Blair; Samuel Grader; Eileen Prentice
Subject: RE: Collin County contract packet for IDCU/SUR
Importance: High

Ms. Paradise,

As requested, please see the attached budget and application for the FY2020 – FY2021 IDCU SUR funding. Although the face page reflects the award amount indicated in the email ($342,445), please note that the proposed funding is insufficient to cover the anticipated salary and fringe costs for two full time epidemiologists for our county. From the time of our previous contract application, Collin County has adjusted salaries to keep pace with the market and we are currently on track to surpass our grant budget with salary and fringe alone for FY2019. To that end, our intention remains to have two full time epidemiologists support the program in the coming contract period and the attached budget reflects the total program costs of $417,036. Please advise us as to whether there is a possibility that DSHS would increase our award amount to cover the remaining salary and fringe or if it is preferable to update the budget to

reflect that the grant will cover less than (1) FTE for each position and the personnel and fringe expenses over and above the award amount will need to be absorbed by the county (Other Funds) . Please let me know if you wish to discuss or need additional documentation.

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)
A.	Personnel	$305,882	$305,882	$0	$0	$0
B.	Fringe Benefits	$104,214	$104,214	$0	$0	$0
C.	Travel	$2,200	$2,200	$0	$0	$0
D.	Equipment	$0	$0	$0	$0	$0
E.	Supplies	$1,000	$1,000	$0	$0	$0
F.	Contractual	$0	$0	$0	$0	$0
G.	Other	$3,740	$3,740	$0	$0	$0
H.	Total Direct Costs	$417,036	$417,036	$0	$0	$0
I.	Indirect Costs	$0	$0	$0	$0	$0
J.	Total (Sum of H and I)	$417,036	$417,036	$0	$0	$0
K.	Program Income - Projected Earnings	$0	$0			

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

	Budget Catetory	Distribution Total	Budget Total	Budget Category	Distribution Total
Check Totals For:	**Personnel**	**$305,882**	**$305,882**	**Fringe Benefits**	**$104,214**
	Travel	**$2,200**	**$2,200**	**Equipment**	**$0**
	Supplies	**$1,000**	**$1,000**	**Contractual**	**$0**
	Other	**$3,740**	**$3,740**	**Indirect Costs**	**$0**

TOTAL FOR:	**Distribution Totals**	**$417,036**	**Budget Total**

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

Thank you,

Joann L. Gilbride
Healthcare Coordinator
Collin County Health Care Services
825 N. McDonald #130

McKinney, TX 75069
P: 972-548-5503
F: 972-548-4441

From: Paradise,Caeli (DSHS) [mailto:Caeli.Paradise@dshs.texas.gov]
Sent: Tuesday, January 29, 2019 9:24 AM
To: Joann Gilbride; Candy Blair; Eileen Prentice; Samuel Grader
Subject: Collin County contract packet for IDCU/SUR

Hello,

The current infectious disease surveillance (IDCU/SUR) contract (537-18-0300-00001) for Collin County will expire on August 31, 2019. DSHS is starting the contract development process to replace that contract with a new two-year contract that will begin on September 1, 2019.

The funding amount listed in this email is the same as the current contract but subject to change pending official notification of the 2020-2021 final legislative appropriations.

The anticipated award for this 2-year contract is $342,445. The available funds for FY20 expenditures will be $171,223 and the available funds for FY21 expenditures will be $171,222.

THE BUDGET
Attached is the budget template and another file which includes instructions for completing the budget. **Please complete the Budget to reflect 24 months and a total amount of $342,445**. Include on the budget the personnel and fringe for Epidemiology staff and the travel to attend the required EPI workshop in Austin for both years of the contract. Other costs are allowed to the extent that they are in line with the guidance contained in the **Uniform Grant Management Standards (UGMS)** document also attached to this email. It will be helpful to review **Attachment A - The General Principles for Determining Allowable Costs, C. Basic Guidelines** on page 13 prior to developing the budget for this contract. Here is a piece of the information you will find in this document which is published by the Texas Comptroller of Public Accounts:

> *To be allowable, costs must be necessary and reasonable for proper and efficient administration of the State award.*

THE FACE PAGE
I have also included **Form A: Face Page** to be complete and return to me. This form has been revised and no longer requires a signature. Most notably, the revised form is now requesting information for a new LHD contact to be copied in DocuSign when the contract is routed to the LHD for signature. The second page of the form contains instructions for completion.

Please return the completed budget and Form A to me by close of business **February 8th, 2019**. DSHS is working on a very tight timeline, so if meeting this deadline is not

possible, please contact me, on a case-by-case basis we may be able to negotiate an alternative deadline.

If you have any questions or have concerns regarding completing and returning the attached documents, please contact me at caeli.paradise@dshs.texas.gov or 512-776-3767.

Caeli Paradise, CTCM
Contract Manager
Contract Management Section(CMS)
Department of State Health Services(DSHS)
P.O. Box 149347
Austin, Texas 78714 – Mail Code 1990
Phone: (512) 776-3767
Fax: (512) 776-7391
Caeli.paradise@dshs.texas.gov

Department of State Health Services

FORM A: FACE PAGE

Proposal for Financial Assistance

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

CONTRACTOR 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 75071

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

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

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

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

7) PROPOSED BUDGET PERIOD: Start Date: ***09/01/2019*** End Date: ***08/31/2021***

8) COUNTIES SERVED BY PROJECT:

COLLIN COUNTY

9) AMOUNT OF FUNDING REQUESTED: $342,445

10) PROJECTED EXPENDITURES

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

Yes ☐ 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

13) PERSON AUTHORIZED TO SIGN CONTRACT Check if change ☒

Name: CHRIS HILL
Title: COUNTY JUDGE
Phone: 972-548-4635
Fax: 972-548-4699
Email: chill@co.collin.tx.us

FORM A: FACE PAGE INSTRUCTIONS

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

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

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

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

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

5) FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER - Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit).

6) TYPE OF ENTITY - Check the type of entity as defined by the Secretary of State at http://www.sos.state.tx.us/corp/businessstructure.shtml
and/or the Texas State Comptroller at https://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.

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

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

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

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

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

13) PERSON AUTHORIZED TO SIGN CONTRACT - Enter the name, title, phone, fax, and email address of the person authorized to sign the contract. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

General Instructions for Completing Budget Forms
DSHS Costs Only Budgeted on Detail Category Pages

(Examples and instructions for completing the Budget Category Detail Templates are in a separate Excel file located under Templates for Cost Reimbursement Budgets located at :
http://www.dshs.state.tx.us/grants/forms.shtm

* Enter the legal name of your organization in the space provided for "Legal Name of Respondent" on Form I -Budget Summary; doing so will populate the budget category detail templates with your organizations name.

* Complete each budget category detail template. Instructions for completing each budget category detail template are in a separate document. If a primary budget category detail template does not accommodate all items in your budget, use the respective supplemental budget template at the end of this workbook. The total of each supplemental category detail budget template will automatically populate to the last line of the respective primary budget category template.

* After you have completed each budget category detail form, go to Form I-Budget Summary and input other sources of funding manually (if any) in Columns 3 - 6 for each budget category.

* 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.

* Enter the total amount of "Program Income" anticipated for this program in row "K" under the "Total Budget" column (1). The total program income budgeted will be automatically allocated to each funding source based on the percentage of funding of the total budget. Information on program income is available in the DSHS Contractors Financial Procedures Manual located at the following web site: http://www.dshs.state.tx.us/contracts/

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	$305,881	$250,211	$0	$0	$0	$55,670
B. Fringe Benefits	$104,201	$85,247	$0	$0	$0	$18,954
C. Travel	$2,200	$2,200	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$1,047	$1,047	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$3,740	$3,740	$0	$0	$0	$0
H. Total Direct Costs	$417,069	$342,445	$0	$0	$0	$74,624
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$417,069	$342,445	$0	$0	$0	$74,624
K. Program Income - Projected Earnings	$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**	**$305,881**	**$305,881**	**Fringe Benefits**	**$104,201**	**$104,201**
	Travel	**$2,200**	**$2,200**	**Equipment**	**$0**	**$0**
	Supplies	**$1,047**	**$1,047**	**Contractual**	**$0**	**$0**
	Other	**$3,740**	**$3,740**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$417,069**	**Budget Total**	**$417,069**

*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
Epidemiologist-P	N	Coordinates epidemiology services and disease investigation	0.82	NA	$6,593.73	24	$129,448
Epidemiologist-P	N	Coordinates epidemiology services and disease investigation	0.82	NA	$6,151.33	24	$120,763
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$250,211

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

FRINGE BENEFITS: FICA/Medicare (salary x 0.0765), Insurance Premiums ($1100 for medical/dental/RX and $4.95 for term life per month), Long Term Disability (salary x 0.0026), Short Term Disability $3.20/month, Long Term Care $26.25/month, Retirement (salary x 0.08), Supplement Death Benefit (salary x 0.0025), Unemployment Insurance (salary x 0.001)

Fringe Benefit Rate %	34.07%
Fringe Benefits Total	$85,247

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	
DSHS Epi / Surveillance Training (FY2020)	Providing employees with up to date training on disease investigations, CDC and DSHS guidance, epidemiology and surveillance techniques	Austin, TX	3 days, 2 employees	Mileage	$150
				Airfare	
				Meals	$300
				Lodging	$550
				Other Costs	
				Total	$1,000
DSHS Epi / Surveillance Training (FY2021)	Providing employees with up to date training on disease investigations, CDC and DSHS guidance, epidemiology and surveillance techniques	Austin, TX	3 days, 2 employees	Mileage	$150
				Airfare	
				Meals	$300
				Lodging	$550
				Other Costs	
				Total	$1,000
				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

Revised: 7/6/2009

Total for Conference / Workshop Travel $2,000

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Local travel for educational presentations to community stakeholders and site visits for disease investigations	345	$0.580	$200		$200
			$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 $200

Other / Local Travel Costs: $200 Conference / Workshop Travel Costs: $2,000 **Total Travel Costs:** $2,200

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
General Office Supplies	Supplies needed for filing, creating epidemiology reports, printing educational presentations, correspondence	$1,047
		$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: **$1,047**

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 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
NONE						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
						$0
					TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS	$0

Total Amount Requested for CONTRACTUAL: $0

Revised: 7/6/2009

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
Monthly Service-iPhone	Required for the cell phone--$55/month data usage plan x 24 months X 2 users/phones	$2,640
Reference Manuals	Publications used for education and/or training on epidemiology, surveillance, or disease investigations	$1,000
Printed Brochures and Educational Materials	Brochures, flyers, posters, handouts and other items used in community education to prevent the spread of infectious diseases	$100
		$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: **$3,740**

Revised: 7/6/2009