Inter-Local Application for Tuberculosis Prevention and Control for FY 2021 Federal Funds

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

TB Services Branch
201 West Howard Lane
Austin, Texas 78753

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Department of State Health Services
Form A Face Page

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, 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 Rd., Suite 3100, McKinney, TX 75070

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 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: January 1, 2021 End Date: December 31, 2021

8) COUNTIES SERVED BY PROJECT:

COLLIN

9) AMOUNT OF FUNDING REQUESTED: $114,386

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: Linda Riggs
Phone: 972-548-4643
Fax: 972-548-4696
Email: countyauditor@collincountytx.gov

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

14) DATE 6/11/2020

15) SIGNATURE OF AUTHORIZED REPRESENTATIVE

(Docusign)

DOCUSIGN SIGNATURE INFORMATION	
16) DOCUSIGN - SIGNATURE AUTHORITY Name: Judge Chris Hill Email Address: chill@co.collin.tx.us Documents to Sign: Signature Page ☒	17) DOCUSIGN - SECONDARY SIGNATURE AUTHORITY Name: Laura Thomas, Grant Accountant / Auditor's Office Email Address: (this email address must be different from the Signature Authority email address) llthomas@co.collin.tx.us Documents to Sign: Signature Page ☐
	If by default there will be a secondary signature authority to sign specific forms of this contract (Example: Secondary Signature Authority will FFATA Form and Lobbying Forms), please list the documents the Secondary Signature Authority will sign in the Special Instructions space below. If the Special Instructions section is completed below, the contract will be routed to the Secondary Signature Authority, after the Signature Page is signed by the Signature Authourity. Special Instructions: Secondary Authority will complete the FFATA Form and the Signature Authority will sign the contract. Please provide full contract to all the parties.

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.

16) DOCUSIGN SIGNATURE AUTHORITY – Enter the name, email address, and list the contract documents of the person authorized to sign the contract via DocuSign.

17) DOCUSIGN SECONDARY SIGNATURE AUTHORITY –If a Secondary Signature Authority exists, enter the name, email address, and list the contract documents of the person authorized to sign via DocuSign. Please ensure the email address listed for the Secondary Signature Authority in Box #17 is different from the email address for the Signature Authority in Box # 16. Please provide Special Instructions if a Secondary Signature Authority is to sign the FFATA, Lobbying Form, or any other forms other than the Signature Page.

FORM B: APPLICATION TABLE OF CONTENTS AND CHECKLIST

Legal Business Name of Respondent: COLLIN COUNTY HEALTH CARE SERVICES

This form is provided as your Table of Contents and to ensure that the application is complete, proper signatures are included, and the required attachments have been submitted. Be sure to indicate page number.

FORM	DESCRIPTION	Included
A	Face Page - completed, and proper signatures and date included	X
B	Application Table of Contents and Checklist - completed and included	X
C	Contact Person Information - completed and included	X
D	Administrative Information – completed and included	X
E	Organization, Resources and Capacity included	X
F	Performance Measures	X
G	Budget Summary Form - completed and included (with most recently approved indirect cost agreement and letters of good standing if applicable)	X
H	Budget Category Detail Forms - completed and 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 Section.

Emergency Contact:	CANDY BLAIR	Mailing Address	
Title:	CCHCS ADMINISTRATOR	Street:	825 N. MCDONALD #130
Phone:	972-548-5504	City:	MCKINNEY
Fax:	972-548-4441	County:	COLLIN COUNTY
Email:	CBLAIR@CO.COLLIN.TX.US	State, Zip:	TEXAS, 75069
Contact:	JOANN GILBRIDE	Street:	825 N. MCDONALD #130
Title:	HEALTHCARE COORDINATOR	City:	MCKINNEY
Phone:	972-548-5503	County:	COLLIN COUNTY
Fax:	972-548-4441	State, Zip:	TEXAS, 75069
Email:	JGILBRIDE@CO.COLLIN.TX.US		
Contact:	LAURA THOMAS	Street:	2300 BLOOMDALE RD, SUITE 3100
Title:	GRANT ACCOUNTANT	City:	MCKINNEY
Phone:	972-548-4511 Ext:	County:	COLLIN
Fax:	972-548-4751	State, Zip:	TEXAS, 75071
Email:	LLTHOMAS@CO.COLLIN.TX.US		
Contact:		Street:	
Title:		City:	
Phone:	Ext:	County:	
Fax:		State, Zip	
Email:			
Contact:		Street:	
Title:		City:	
Phone:	Ext:	County:	
Fax:		State, Zip	
Email:			

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 complete 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.

Last Name:	HILL	Mailing Address (incl. street, city, county, state, & zip):
First Name:	CHRIS	2300 BLOOMDALE RD., SUITE 4192
Middle Name:		MCKINNEY, TX 75071
Last Name:		Mailing Address (incl. street, city, county, state, & zip):
First Name:		
Middle Name:		

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
HHS000483500001	TB State Contract
HHS0000686100011	TB Federal Contract
537-18-0348-00001	Zika Contract
HHS000436300030	IDCU SUR Contract
HHS000485600007	RLSS/LPHS Contract
HHS000119700018	Immunizations
537-18-0128-00001	PHEP / Hazards
537-18-0141-00001	Cities Readiness Initiative
HHS00076980001	COVID-2019

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.

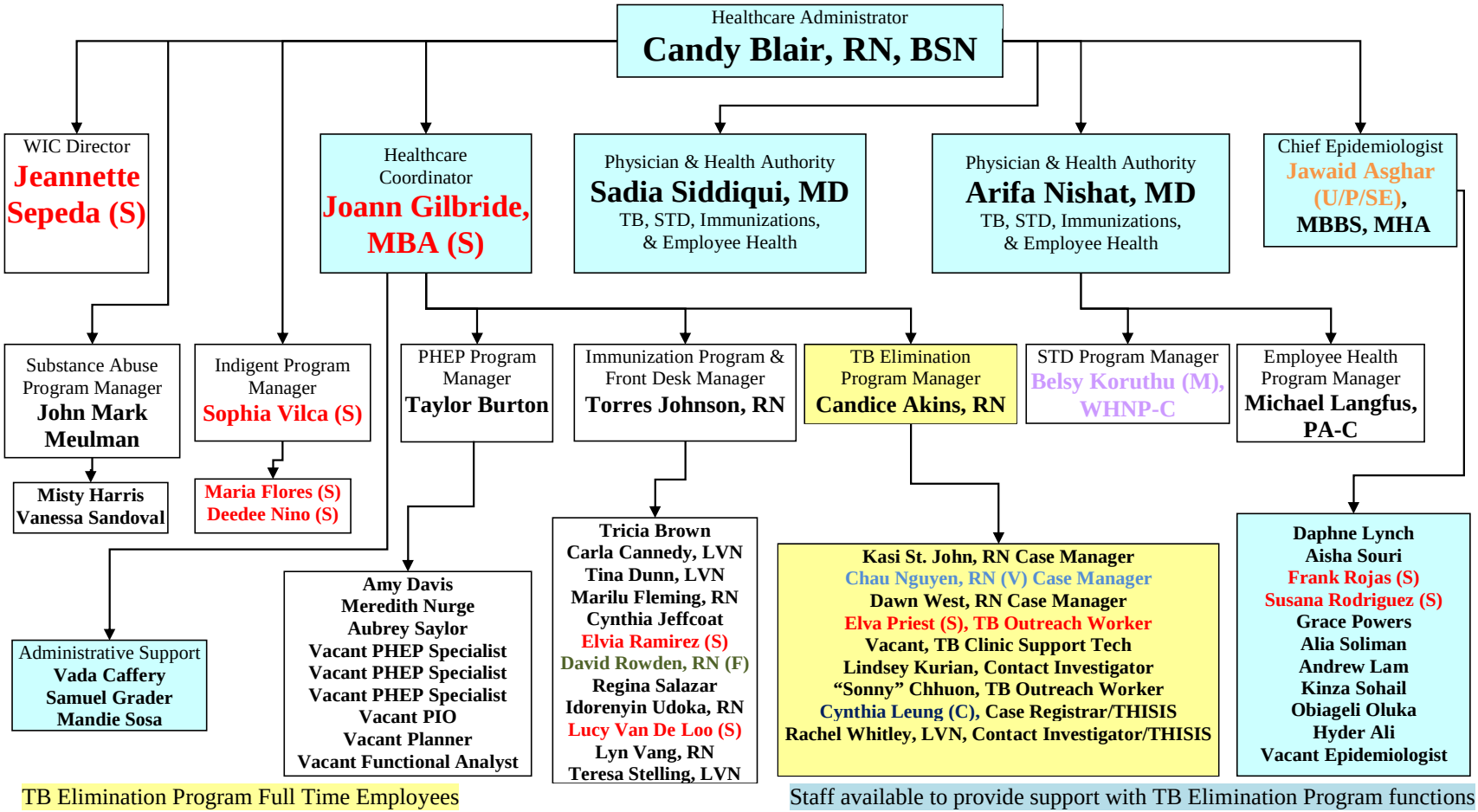
4. Is applicant or any member of applicant's executive management, project management, board members or principal officers:

- 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



TB Elimination Program Full Time Employees

Staff available to provide support with TB Elimination Program functions

(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 6/11/2020

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.

It is not necessary to list the performance measures below. Please refer to the work plan located at the following web link: http://www.dshs.texas.gov/idcu/disease/tb/policies/ where the performance measures may be found.

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 Narrative Report, **due April 1, 2021** 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.