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AGENDA ITEM REQUEST FORM

Hays County Commissioners Court
Tuesdays at 9:00 AM

Request forms are due in Microsoft Word Format via email by 2:00 p.m. on Wednesday.

AGENDA ITEM

Authorize the County Judge to submit a renewal grant application to the Texas Department of State Health Services for the Local Public Health Services program, in the amount of $51,463, to be utilized for staffing in the Hays County Local Health Department.

ITEM TYPE	MEETING DATE	AMOUNT REQUIRED
CONSENT	April 2, 2013	

LINE ITEM NUMBER

AUDITOR USE ONLY

AUDITOR COMMENTS:

PURCHASING GUIDELINES FOLLOWED: N/A **AUDITOR REVIEW:** N/A

REQUESTED BY	SPONSOR	CO-SPONSOR
Hauff	INGALSBE	N/A

SUMMARY

Funding is requested annually to support disease surveillance, tracking and reporting, as well as to develop plans and policies to improve the delivery of public health services within Hays County. Funds will be utilized to provide partial support of the salary and benefits of the Community Health RN Supervisor. This is a renewal application for funding for the period of September 1, 2013 to August 31, 2014 (FY14).

FILED: 04 02 13
HAYS COUNTY COMMISSIONERS' COURT
Resolution # 28899 VOL V PG 125

TEXAS Department of State Health Services

FY 2014 Local Public Health Services
FORM A - FACE PAGE

RESPONDENT INFORMATION

1) LEGAL NAME: HAYS COUNTY - PERSONAL HEALTH DEPARTMENT

2) MAILING Address Information (include mailing address, street, city, county, state and zip code):
HAYS COUNTY GOVERNMENT CENTER
712 SOUTH STAGECOACH TRAIL, STE 1071
SAN MARCOS, TEXAS 78666

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

SAME AS ABOVE

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) : 17460022415002
*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	☐ Nonprofit Organization*	☐ Individual
☒ Regions/Counties/LHD	☐ For Profit Organization*	☐ FQHC
☐ Other Political Subdivision	☐ HUB Certified	☐ State Controlled Institution of Higher Learning
☐ State Agency	☐ Community-Based Organization	☐ Hospital
☐ Indian Tribe	☐ Minority Organization	☐ Private
	☐ Faith-based Organization	☐ Other (specify): _____

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

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

7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: Rebecca Herring, R.N. Phone: (512)393-5569 Fax: (512)393-5530 E-mail: Rebecca_herring@co.hays.tx.us	x **LPHS** $51,463.35

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	**9) SIGNATURE OF AUTHORIZED REPRESENTATIVE**
Name: Bert Cobb, M.D. Title: Hays County Judge Phone: (512)393-2205 Fax: (512)393-2248 E-mail: Bert.cobb@co.hays.tx.us	**10) DATE** 4-2-2013

***Form A – FACE PAGE must be scanned & emailed with signature to** localphteam@dshs.state.tx.us
OR fax to (512) 776-7391

TEXAS Department of State Health Services

FY 2014 Local Public Health Services

Regional and Local Health Services & Compliance Branch

Program Contact Information

Contract Term: September 1, 2013 through August 31, 2014

Legal Name of Applicant: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

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

		Mailing Address (street, city, county, state, & zip):
Contact:	James Garza	2171 Yarrington Rd.
Title:	Director, Development & Community Services	San Marcos
Phone:	(512) 393-2150	Texas
Fax:	(512) 493-1915	78666
E-mail:	James.garza@co.hays.tx.us	

Financial Manager

		Mailing Address (street, city, county, state, & zip):
Contact:	Bill Herzog	712 South Stagecoach Trail, Ste. 1071
Title:	Hays County Auditor	San Marcos
Phone:	(512) 393-2283	Texas
Fax:	(512) 393-2248	78666
E-mail:	bherzog@co.hays.tx.us	

Contract Coordinator

		Mailing Address (street, city, county, state, & zip):
Contact:	Rebecca Herring, R.N.	401-A Broadway
Title:	TB/Communicable Disease Coordinator	San Marcos
Phone:	(512) 393-5569	Texas
Fax:	(512) 393-5530	78666
E-mail:	Rebecca_herring@co.hays.tx.us	

Additional Staff

		Mailing Address (street, city, county, state, & zip):
Contact:	Jeff Hauff	712 Stagecoach Trail, Ste. 1204
Title:	Grants Administrator	San Marcos
Phone:	(512) 393-2209	Texas
Fax:	(512) 393-2248	78666
E-mail:	Jeff.hauff@co.hays.tx.us	

Additional Staff

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

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

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	$36,959	$36,959	$0	$0	$0	$0
B. Fringe Benefits	$14,504	$14,504	$0	$0	$0	$0
C. Travel	$0	$0	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$0	$0	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0	$0	$0
G. Other	$0	$0	$0	$0	$0	$0
H. Total Direct Costs	$51,463	$51,463	$0	$0	$0	$0
I. Indirect Costs	$0	$0	$0	$0	$0	$0
J. Total (Sum of H and I)	$51,463	$51,463	$0	$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 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**	**$36,959**	**$36,959**	**Fringe Benefits**	**$14,504**	**$14,504**
	Travel	**$0**	**$0**	**Equipment**	**$0**	**$0**
	Supplies	**$0**	**$0**	**Contractual**	**$0**	**$0**
	Other	**$0**	**$0**	**Indirect Costs**	**$0**	**$0**

TOTAL FOR:	**Distribution Totals**	**$51,463**	**Budget Total**	**$51,463**

*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: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

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
RN SUPERVISOR = E	N	To achieve activies listed on the Project Service Delivery Plan	0.58	RN	$5,321.17	12	$36,959
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
							$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							$0
					SalaryWage Total		$36,959

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

FICA = $36,959 x 6.2% = $2,291.44
MEDICARE = $36,959 x 1.45% = $535.90
RETIREMENT = (($36,959 / 12) * 4 * 11.32%) + (($36,959 / 12) * 8 * 12.46%) = $4,464.61
MEDICAL INSURANCE = $12,459.39 *0.5788 = $7,211.50

Fringe Benefit Rate %	39.24%
Fringe Benefits Total	$14,504

Revised: 7/6/2009

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location City/State	Number of: Days/Employees	Travel Costs	
				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

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: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

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
				$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: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

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
		$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**

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates $100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly rate, unit rate, lump sum amount)	TOTAL
						$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: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	Purpose & Justification	Total Cost
		$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: HAYS COUNTY PERSONAL HEALTH DEPARTMENT

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.**

RATE:
TYPE:
BASE:

_____ **Note:** Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

_____ A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date. The CFPM is available on the following internet web link: http://www.dshs.state.tx.us/contracts/

GO TO PAGE 2 (below)

Page 2, FORM I - 7 Indirect Costs

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**

EXHIBIT A
FY 2014 Request for Local Public Health Services Funds
Project Service Delivery Plan

Texas Department of State Health Services

Local Health Department: HAYS COUNTY PERSONAL HEALTH DEPT.

Contract Term: September 1, 2013 through August 31, 2014

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.***

1. **Public health policy planning and development**
2. **Communicable disease reporting and outbreak control in the community**

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

1. **Development and implementation of policies/plans for community efforts to improve public health**
2. **Diagnose and investigate community health problems and 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.)***

1. **Throughout FY 2014 will disseminate policies and plans regarding critical public health information to partners in an accurate and timely manner.**
2. **By FY 2014 end at least 95% of notifiable conditions will be investigated and reported**

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.***

1. **95% of policies and plans regarding critical public health information are disseminated to partners in an accurate and timely manner.**
2. **95% of notifiable conditions will be investigated, reported, and followed as shown in communicable disease database**

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.*
1.1.1 Prepare/disseminate changes and/or up-dates to policies, plans, or information regarding public health issues to partners within 7 days.	1.1.1 Identify and document time required to disseminate changes or updates and information.	1.1.1 Documentation of changes or updates disseminated to partners
1.1.2 Maintain database of local public health system partners to ensure rapid dissemination of critical information.	1.1.2 Review database with partners to affirm contact information is correct.	1.1.2 Database of partners involved in planning public health policy
1.1.3 Plan to host and/or attend educational meetings with partners to discuss critical public health issues quarterly. Continue distribution of LHD-based newsletter to provide current local and regional vaccine preventable and other communicable disease information to partners.	1.1.3 Results of meetings with partners will be used to improve future educational efforts and policy development. Will actively solicit feedback and suggestions from local partners to enhance newsletter efficacy.	1.1.3 Keep meeting records of sign-in sheets and discussions of policies and plans. Maintain a file of feedback correspondence from partners related to newsletter for ongoing evaluation of efficacy.
2.1.1 Receive/respond to communicable diseases reported within established guidelines and timelines.	2.1.1 Respond to reports received from area providers and NEDSS confirming receipt/response for communicable disease investigations per CDC/DSHS guidelines.	2.1.1 Maintain database in NEDSS for all communicable disease investigations
2.1.2 Analyze results of data collected monthly.	2.1.2 Will review activities in terms of adherence to CDC and DSHS communicable disease guidelines and protocols.	2.1.2 Records of reports and investigations
2.1.3 Identify areas where communicable diseases are most frequently reported in county to pinpoint possible clusters of concern.	2.1.3 Compare numbers of communicable diseases reported from each entity , e.g. as noted in NEDSS database and/or from individual sources. Will notify partners in areas where disease clusters are noted, for control options and educational opportunities.	2.1.3 Maintain list of communicable disease reported by local entities disseminated to local providers, e.g. hospitals, Physician offices, clinics, and school Nurses. Will maintain a file of all communication with partners related to disease clusters.