

AUG 11 2014

20407



## EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/13)

Instructions for completing the EDS and the Contract process.

Received

AUG 12 ENT'D

DOA Contracts

1. Please read the guidelines on the back of this form.
2. Please type all information.
3. Check all boxes that apply.
4. For amendments / renewals, attach original contract.
5. Attach additional pages if necessary.

1. EDS Number: A70-4-070538		2. Date prepared: 6/26/2014	
3. CONTRACTS & LEASES			
<input type="checkbox"/> Professional/Personal Services <input checked="" type="checkbox"/> Grant <input type="checkbox"/> Lease <input type="checkbox"/> Attorney <input type="checkbox"/> MOU <input type="checkbox"/> QPA		<input type="checkbox"/> Contract for procured Services <input type="checkbox"/> Maintenance <input type="checkbox"/> License Agreement <input checked="" type="checkbox"/> Amendment# <u>1</u> <input type="checkbox"/> Renewal # _____ <input type="checkbox"/> Other _____	
FISCAL INFORMATION			
4. Account Number: 61900-30700.571100		5. Account Name: ISDH DOAg Fund	
6. Total amount this action: \$7,320.00		7. New contract total: 185,708.57	
8. Revenue generated this action: \$0.00		9. Revenue generated total contract: \$0.00	
10. New total amount for each fiscal year:			
Year 2014		\$178,388.57	
Year 2015		\$7,320.00	
Year		\$	
Year		\$	
TIME PERIOD COVERED IN THIS EDS			
11. From (month, day, year): 10/1/2013		12. To (month, day, year): 9/30/2014	
13. Method of source selection:			
<input type="checkbox"/> Bid/Quotation <input type="checkbox"/> Emergency <input type="checkbox"/> Negotiated <input checked="" type="checkbox"/> RFP# <u>12-50</u> <input type="checkbox"/> Other (specify) _____			
14. Agency fiscal officer or representative approval			
41. Date Approved 8/11/14			
42. Budget agency approval			
43. Date Approved 8/15/14			
44. Attorney General's Office approval			
45. Date Approved 8/21/2014			
46. Agency representative receiving from AG			
47. Date Approved			

## AGENCY INFORMATION

14. Name of agency: Department of Health	15. Requisition Number: 0000026207
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16. Address: 2 N. Meridian Street Indianapolis, IN 46204
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## AGENCY CONTACT INFORMATION

17. Name: Steven A. Gale	18. Telephone #: 317/233-9243
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19. E-mail address: sgale1@isdh.in.gov
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## COURIER INFORMATION

20. Name: Michael P. Mendyk	21. Telephone #: 317-233-7853
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22. E-mail address: mmendyk@isdh.in.gov
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## VENDOR INFORMATION

23. Vendor ID # 0000053934
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24. Name: STUBEN COUNTY GOVERNMENT	25. Telephone #: (260) 668-1000
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26. Address: STUBEN COUNTY HEALTH DEPARTMENT 317 S WAYNE STREET STE 2 H ANGOLA, IN 46703
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27. E-mail address: inwic5001@gmail.com
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28. Is the vendor registered with the Secretary of State? (Out of State Corporations, must be registered) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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29. Primary Vendor: M/WBE/IN-Veteran Minority: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Women: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IN-Veteran: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	30. Primary Vendor Percentages 100.0 %
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31. Sub Vendor: M/WBE/IN-Veteran Minority: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Women: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IN-Veteran: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	32. If yes, list the %: Minority: _____ % Women: _____ % IN-Veteran: _____ %
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33. Is there Renewal Language in the document? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	34. Is there a "Termination for Convenience" clause in the document? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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35. Will the attached document involve data processing or telecommunications systems(s)?	Yes: IOT or Delegate has signed off on contract
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36. Statutory Authority (Cite applicable Indiana or Federal Codes): 42 U.S.C. 1786
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37. Description of work and justification for spending money. (Please give a brief description of the scope of work included in this agreement.) The vendor administers the Women, Infants, and Children's (WIC) program in Steuben County. The Indiana Supplemental Food Program for Women, Infants and Children provides nutritious supplemental foods, nutrition education, breastfeeding support, and health care referrals to women, infants and children up to the age of five who are at nutritional risk and meet federal income guidelines (up to 185% of poverty)
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38. Justification of vendor selection and determination of price reasonableness: This entity was awarded the contract through the State procurement bid process, RFP #12-50. Budgets were negotiated by ISDH and the vendor in order to implement cost containment measures. Funding for staffing is allocated based on participant caseload and funding for supplies is based on a flat rate per participant.
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39. If this contract is submitted late, please explain why: (Required if more than 30 days late.)
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RECEIVED

AUG 16 2014

OAG-ADVISORY



73966-001

mc

# REQUISITION

Ship To: State Department of Health  
Section 2-C  
2 N MERIDIAN ST  
INDIANAPOLIS IN 46204

Bill to: State Department of Health  
Section 2-C  
2 N MERIDIAN ST  
INDIANAPOLIS IN 46204

Requisition No. 0000026207	Date 07/29/2014	Required Date	Page 1 of 1
Fund/Account:	61900 / 571100		
Dept Number:	195070		
Project Number:	40010557WICAD14		
Requisition Number:	0000026207		
Requestor:	GALLEN Allen, Gary-400		
Agency Number:	00400 Department of Health		
Facility:			

## MUST COMPLETE FOR ICPR

☐ Print REQ  
☐ Streamline Eligible

Line	Item	Description	Quantity	UOM	Unit Price	Ext Amt
This entity was awarded the contract through the State procurement bid process, RFP #12-50. Budgets were negotiated by ISDH and the vendor in order to implement cost containment measures. Funding for staffing is allocated based on participant caseload and funding for supplies is based on a flat rate per participant.						
1-1		Amend #1 A70-4-070538, 10/1/13-9/30/14	1.0000	LO	7,320.0000	7,320.00

Vendor: 0000053934 STEUBEN COUNTY GOVERNMENT

<< PLEASE SEE ATTACHED CONTRACT  
CONTRACT DATE 10/1/13-9/30/14  
CONTRACT AMOUNT \$7,320.00

EXISTING PURCHASE ORDER # 14528114 >>

The following UN/CEFACT Unit of Measure  
Common Codes are used in this document:  
LO Lot

Requisition Total \$ 7,320.00

Requestor Signature	I certify that the item[s] requested is [are] necessary for the operation of this State Agency.	
	Printed Name of Agency Head or Authorized Employee	Authorized Signature

**Amendment No. 1**  
**EDS Number A70-4-070538 (WIC)**

This is an Amendment to the existing **U.S.D.A. WIC Grant Agreement** entered into by and between the **Indiana State Department of Health** (hereinafter referred to as the "State") and **Steuben County Health Department** (hereinafter referred to as the "Grantee") for the period from **October 1, 2013** through **September 30, 2014**, in the amount of **\$178,389**.

In consideration of the mutual undertakings and covenants hereinafter set forth, the parties agree as follows:

The amount of the Grant Agreement is being increased by **\$7,320** making the new total of the Grant Agreement **\$185,709**. The additional funds will be used to **provide personnel, fringe, nutrition education activities, outreach activities, travel and other miscellaneous needs for the agency**. See Attachment B-1, attached hereto, which replaces Attachment B, made a part hereof, and incorporated herein by reference as a part of this Grant Agreement.

All other matters previously agreed to and set forth in the original Grant Agreement and not affected by this Amendment shall remain in full force and effect.


**Non-Collusion and Acceptance**

The undersigned attests, subject to the penalties of perjury, that he/she is the Grantee, or that he/she is the properly authorized representative, agent, member or officer of the Grantee, that he/she has not, nor has any other member, employee, representative, agent or officer of the Grantee, directly or indirectly, to the best of his/her knowledge, entered into or offered to enter into any combination, collusion or agreement to receive or pay, and that he/she has not received or paid any sum of money or other consideration for the execution of this Grant Agreement other than that which appears upon the face hereof.

**The rest of this page has been left blank intentionally.**

In Witness Whereof, the Grantee and the State of Indiana have, through duly authorized representatives, entered into this Grant Agreement Amendment. The parties having read and understanding the foregoing terms of the Grant Agreement Amendment do by their respective signatures dated below agree to the terms thereof.

Accepted By:

X   
TED CRISMAN, M.D.  
HEALTH OFFICER  
STEBEN COUNTY HEALTH DEPARTMENT

DATE:

7-30-14


Attested By:

  
KIM KOOMLER  
AUDITOR  
STEBEN COUNTY

DATE:

7-28-2014

Recommended and Approved By:

 (for)  
WILLIAM C. VANNES II, MD  
STATE HEALTH COMMISSIONER  
INDIANA STATE DEPARTMENT OF HEALTH

DATE:

8/11/14


Approved:

 (for)  
JESSICA ROBERTSON, COMMISSIONER  
DEPARTMENT OF ADMINISTRATION  
STATE OF INDIANA

DATE:

8/13/14


Approved:

 (for)  
BRIAN E. BAILEY, DIRECTOR  
STATE BUDGET AGENCY  
STATE OF INDIANA

DATE:

8/15/14

Approved as to Form and Legality:

 (for)  
GREGORY F. ZOELLER  
ATTORNEY GENERAL OF INDIANA

DATE:

8/21/2014

**Attachment B1 - Budget Summary**



**Indiana State  
Department of Health**



**Local Agency Budget**

<b>Name of Organization:</b>	Steuben County Health Department		
<b>Employer ID Number (EIN)</b>			
<b>Breastfeeding Region</b>	Delaware	<b>Federal Fiscal Year</b>	2014

<b>Address:</b>	317 South Wayne Street, Suite 3-C		
<b>City:</b>	Angola	<b>State:</b>	Indiana
<b>Zip:</b>	46703-1938		

<b>Phone:</b>	(260) 668-1000, ext. 1050	<b>Fax:</b>	(260) 665-5821
<b>Website:</b>			

<b>Name of Chief Executive:</b>	Ted J. Crisman, M.D.		
<b>Title:</b>	Health Officer	<b>Phone:</b>	
<b>Email:</b>	inwic5001@gmail.com		

<b>Name of Program Contact:</b>	Carolyn Nagle		
<b>Title:</b>	WIC Coordinator	<b>Phone:</b>	
<b>Email:</b>			

<b>Clinic Operation Caseload</b>	1195	<b>Breastfeeding Promotion Caseload</b>	171
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<b>WIC Nutrition Services &amp; Admin (NSA) Total Costs:</b>	<b>\$</b>	<b>185,708.57</b>
<b>Breastfeeding Promotion Costs:</b>	<b>\$</b>	<b>5,096.87</b>
Personnel - Salary:	\$	3,604.00
Personnel - Fringe:	\$	1,104.07
Travel:	\$	388.80
<b>Clinic Operations Costs:</b>	<b>\$</b>	<b>180,611.70</b>
Personnel - Salary:	\$	119,372.00
Personnel - Fringe:	\$	36,389.78
Travel - Clinic Services:	\$	48.60
Travel - Nutrition Education:	\$	-
Supplies:	\$	3,513.30
Communication:	\$	1,950.00
Contract Services:	\$	830.00
Space Costs:	\$	18,508.02