20586

OCT 02 2014

EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-06)

Instructions for completing the EDS and the Contract Process

Received

OCT 03 RECT

OAG 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.

11/24

1. EDS Number:	2. Date prepared:
A70-4-106092	9/4/2014 DS

3. CONTRACTS & LEASES

___ Professional/Personal Services	___ Contract for procured Services
X Grant	___ Maintenance
___ Lease	___ License Agreement
___ Attorney	X Amendment# 1
___ MOU	___ Renewal #
___ QPA	___ Other

FISCAL INFORMATION

4. Account Number:	5. Account Name:
61910-94000.573100	ISDH DHHS Fund
6. Total amount this action: $39,902.00	7. New contract total: 135,326.00
8. Revenue generated this action: $0.00	9. Revenue generated total contract: $0.00

10. New total amount for each fiscal year :

Year 2014 $135,326.00
Year ___ $___
Year ___ $___
Year ___ $___

TIME PERIOD COVERED IN THIS EDS

11. From (month, day, year):	12. To (month, day, year):
1/1/2014	12/31/2014

13. Method of source selection:

X Negotiated
___ Bid/Quotation ___ Emergency ___ Special Procurement
___ RFP# ___ Other *(specify)* ___

AGENCY INFORMATION

14. Name of agency:	15. Requisition Number:
Department of Health	0000024341

16. Address: 2 N. Meridian Street, Indianapolis, IN 46204

AGENCY CONTACT INFORMATION

17. Name:	18. Telephone #:
Sarah Burkholder	317/233-7545

19. E-mail address: sburkholder@isdh.in.gov

COURIER INFORMATION

20. Name:	21. Telephone #:
Rebecca Chauhan	317-233-7558

22. E-mail address: rchauhan1@isdh.in.gov

VENDOR INFORMATION

23 Vendor ID # 0000003310

24. Name:	25. Telephone #:
HEALTH & HOSPITAL CORP OF MARION COUNTY	317-221-2110

26. Address: HEALTH & HOSPITAL CORP OF MARION COUNTY, 3838 N RURAL ST, INDIANAPOLIS, IN 46205

27. E-mail address: mgutwein@hhcorp.org

28. Is the vendor registered with the Secretary of State? (Out of State Corporations, must be registered) X Yes ___ No

29. Primary Vendor: M/WBE/IN-Veteran	30. Primary Vendor Percentages
Minority: ___ Yes X No	100.0 %
Women: ___ Yes X No	
IN-Veteran: ___ Yes X No	

31. Sub Vendor: M/WBE/IN-Veteran	32. If yes, list the %:
Minority: ___ Yes X No	Minority: ___ %
Women: ___ Yes X No	Women: ___ %
IN-Veteran: ___ Yes X No	IN- Veteran: ___ %

33. Is there Renewal Language in the document?	34. Is there a "Termination for Convenience" clause in the document?
X Yes ___ No	X Yes ___ No

35. Will the attached document involve data processing or telecommunications systems(s)? ___ Yes: IOT or Delegate has signed off on contract

36. Statutory Authority *(Cite applicable Indiana or Federal Codes)*:
410 IAC 1-2.3

37. Description of work and justification for spending money. *(Please give a brief description of the scope of work included in this agreement.)*

This grant will provide directly observed therapy services and directly observed preventive therapy for high-risk contacts, augmenting the tuberculosis services available in Marion County. Amendment #1 represents the remaining 25% of this annual grant with the addition of an increase of $8,094 for a part time case manager.

RECEIVED

38. Justification of vendor selection and determination of price reasonableness:

TB funds from the Centers for Disease Control and Prevention are being awarded to the growing complexity of TB case management and the need to provide additional surveillance and containment activities. The vendor is centrally located in the city being served.

OCT 10 2014

39. If this contract is submitted late, please explain why: *(Required if more than 30 days late.)*

OAG-ADVISORY

40. Agency fiscal officer or representative approval	41. Date Approved	42. Budget agency approval	43. Date Approved
Joseph Jostlund	10/1/14		10/6/14
44. Attorney General's Office approval	45. Date Approved	46. Agency representative receiving from AG	47. Date Approved
DSS	10/15/14		

75896-001

Amendment No. 1
EDS Number A70-4-106092 (TB)

This is an Amendment to the existing **Tuberculosis Cooperative Grant** Grant Agreement entered into by and between the **Indiana State Department of Health** (hereinafter referred to as the "State") and **The Health and Hospital Corporation of Marion County** (hereinafter referred to as the "Grantee") for the period from **January 1, 2014** through **December 31, 2014**, in the amount of **$95,424**.

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 **$39,902** making the new total of the Grant Agreement **$135,326**. The additional funds will be used to **provide the remaining 25% of the annual grant for a part time case manager**. See Attachment A-1, attached hereto, which replaces Attachment A, 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:

MATTHEW GUTWEIN
PRESIDENT/EXECUTIVE DIRECTOR
THE HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY

DATE: 9-26-14

Accepted By:

VIRGINIA CAINE, M.D.
HEALTH OFFICER
MARION COUNTY HEALTH DEPARTMENT

DATE: 9/19/14

Recommended and Approved By:

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

DATE: 10/1/14

Approved:

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

DATE: 10/6/14

Approved:

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

DATE: 10/8/14

Approved as to Form and Legality:

(for)
GREGORY F. ZOELLER
ATTORNEY GENERAL OF INDIANA

DATE: 10/15/14

Attachment A-1
A70-4-106092
Marion County Public Health Department

PURPOSE OF GRANT AGREEMENT:

To provide directly observed therapy (DOT) services and directly observed preventive therapy (DOPT) for high-risk contacts, augmenting the TB services available in Marion County beginning January 1, 2014 and ending December 31, 2014. Seventy-five (75) percent of this grant has already been awarded. This amendment is for the remaining 25%.

SERVICE RECIPIENTS:

Individuals living in Marion County.

CONSIDERATION FOR DELIVERABLES AND SCHEDULE OF PAYMENT:

REQUIRED ACTIVITIES	MEASURABLE CRITERIA	ANNUAL RATE FY 2013	75% of Annual Budget	Remaining 25%
Three Community Health Workers (CHWs) will be responsible for delivering and observing the ingestion of medications, observing, and collecting sputum samples, assisting with contact investigation, educating clients, and arranging for transport as needed to medical appointments related to TB care. TB Community Health Workers may assist local health department TB case management activities.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.	97,380.00	68,535.00	28,845
Part-Time case manager to help with case management activities and clinic activities.	Same as above			
The CHWs interact with and perform Directly Observed Therapy/Directly Observed Preventive Therapy (DOT/DOPT) with TB patients to promote adherence to medical regimens, thus assuring continuity and completion of therapy.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.			

Programs and seminars attended by the CHWs will have a TB/HIV element. HIV counseling and testing will be offered to clients followed through this project.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.			
Activities shall supplement, not supplant the local TB activities necessary for case management, control and prevention of TB in the designated area.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.			
Each CHW will submit *The Tuberculosis Outreach Quarterly Report* (See ATTACHMENT B) to the MCHD TB Program Coordinator and the local supervisor who will sign and address any barriers or problems encountered. A copy of the Report should be sent to the State TB Control Program.	All reports are due by the 10th of the month following the end of each quarter. April 10, 2014 July 10, 2014 October 10, 2014 December 31, 2014			
The TB outreach services provided through this Grant Agreement shall be in accordance with Tuberculosis Program Objectives established by the Indiana State Department of Health (See ATTACHMENT C).	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.			

There will be one Outreach Worker meeting for the CHWs and one Regional meeting during the Grant Agreement Period. Attendance is required.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.			
TB Control Program will participate in monthly case/cohort reviews (when requested) via teleconference or in-person	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols			
Each CHW must complete, or show proof of having completed, an approved course in *HIV Prevention Counseling.*	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.			
Each CHW should be available on an as-needed basis to assist in outbreak situations in other geographical areas of the State.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted.			
Total Salary Costs		**97,380.00**	**68,535.00**	**28,845**
Fringe Benefits		**33,986.00**	**23,919.00**	**10,067**
Travel		**3,960.00**	**2,970.00**	**990**
Total Grant Agreement		**$135,326.00**	**$95,424.00**	**$39,902**
Total Grant (rounded)		**$135,326.00**	**$95,424.00**	**$39,902**

- **Salary:** Three Community Outreach Workers for twelve months @$97,380
    - J. Hare @ $32,012
    - R. Cotterman @ $33,755
    - C. Rader @ $ 25,613

  Part time Nurse case manager @ $6,000
- Fringe Benefits @ 34.9% of salaries = $33,986

- **Travel for DOT/DOPT Visits** (9000 @ 0.44/mile) = $3,960
  Travel expenditures will be reimbursed by the State at the rate customarily paid by the Grantee or the current rate being paid by the State of Indiana, whichever is the lesser.

- **Invoices:**
  Payment shall be due for hours worked and satisfactory completion of Marion County Public Health Department Deliverables. All invoices must be submitted on a monthly basis and accompanied by written documentation of actual expenditures for all claimed items. The Grantee will be paid monthly for hours worked and the deliverables defined and referenced above. Such payment shall be made in arrears upon receipt and approval of invoice.

  Marion County Public Health Department will augment this grant by providing any additional salary or benefits not covered, travel and other activities and expenses related to the delivery of services.