20586

AGENCY INFORMATION

EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-06)

14. Name of agency:

15. Requisition Number:

Instructions for completing	the EDS and the	compage 1/	P C epartment of Health	0000024341
Please read the guideline Please type all informatio Check all boxes that app For amendments / renew	on. ly.		Indianapolis, IN 46204	
Attach additional pages i	f necessary.		AGENCY CONTACT I	NEORMATION
-		11/24	17. Name:	18. Telephone #:
1. EDS Number:	2. Date prepared		Sarah Burkholder	317/233-7545
A70-4-106092	9/4/2014	NS	19. E-mail address:	···
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			sburkholder@isdh.in.gov	
3. CONTRAC	TS & LEASES		COURIER INFO	RMATION
Professional/Personal Services	Contrac	t for procured Services		<u> </u>
X Grant	Mainter	ance	20. Name:	21. Telephone #:
Lease	License	Agreement	Rebecca Chauhan	317-233-7558
Attorney	X Amend	nent#1_	22, E-mail address:	
MOU	Renewa	nl #	rchauhan1@isdh.in.gov	
QPA	Other		VENDOR INFO	RMATION
EISCAL INS	ORMATION		23 Vendor ID # 0000003310	·
			24. Name:	25. Telephone #:
4, Account Number: 61910-94000.573100	5, Account Na	ime: HHS Fund	HEALTH & HOSPITAL CORP OF MARION (COUNTY 317-221-2110
6. Total amount this action:	7. New contra		26. Address:	205
\$39,902.00	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	135,326.00	HEALTH & HOSPITAL CORI MARION COUNTY	FUF
8. Revenue generated this action:	9:Revenue g	enerated total contract:	3838 N RURAL ST	
\$0.00	1	\$0.00	iNDIANAPOLIS, IN 48205 27, E-mail address; mgutwein@hbcorp.org	
10. New total amount for each fiscal year	r:			60 9.40 65. · ·
Year 2014 \$135,326.00			28. Is the vendor registered with the Secretary of Corporations, must be registered) X Yes	
Year \$	•		29, Primary Vendor; M/WBE/IN-Veteran	30. Primary Vendor Percentages
Year \$			Minority: Yes X No	
Year S	•		Women: Yes X No	100.0 %
			IN-Veteran: Yes X No	
TIME PERIOD CO	VESED IN THE	EDE	31. Sub Vendor: M/WBE/IN-Veteran	32. If yes, list the %:
TIME PERIOD CO	VERED IN THIS		Minority: Yes X No	Minority: %
11. From (month, day, year):	12. To (month, d	ay, year):	Women: Yes X No	Women: %
1/1/2014	12/31/2014		IN-Veteran: Yes X No	IN- Veteran: %
13. Method of source selection:		Negotiated	33. Is there Renewal Language in	34. Is there a "Termination for
Bid/QuotationEmerge	 	Special Procurement	the document?	Convenience" clause in the
RFP# Other (s	specify)		X Yes No	document? X Yes No
35. Will the attached document involve data		romminications systematel	Yes: IOT or Delegate has si	
35. Will the analyse document involve than	—		Yes: 101 or Delegate has si	gned ou on contract
36. Statutory Authority (Cite applicable Ind 410 IAC 1-2.3	liana or Federal ('odes):		
37. Description of work and justification for	spending money	(Please give a brief descrip	tion of the scope of work included in this agreement.)
This grant will provide directly observed th	erapy services and d	rectly observed preventive therap	by for high-risk contacts, augmenting the tuberculosis service	es available in Marion
			n increase of \$8,094 for a part time case manager.	
<u> </u>	_		<u> </u>	RECEIVED
7	trol and Prevention a	re being awarded to the growing	complexity of TB case management and the need to provide	
and containment activities. The vendor is o	ecuratry speaked at th	vay vary savet.		OCT 1 0 2014
30 If this contract is orderisted less alone	evolain when /Dar	saired if more than 20 days to	sta i	
39. If this contract is submitted late, please of	ғардан w ау: (Кед	uirea ij more inan 30 aays id	ne.j	OAG-ADVISORY
40. Agency fiscal officer or representative ap	pproval	41. Date Approved	42. Budget agency approval	43. Date Approved

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 Cutwin	Mu	
_ II (WWWW Dulluen-	214	
INVITUEAA COTAAEIN	- 0	•
PRESIDENT/EXECUTIVE DIRECTOR		•
THE HEALTH AND HOSPITAL CORPORATION	N OF	
MARION COUNTY		•
(1-21 11)	•	
DATE: 7 76-17	,	
•		1
•		Accepted By:
•		Virginia A. Carne
<u>.</u>		Myma N. Came
		VIRGINIA CAINE, M.D.
		HEALTH OFFICER
	•	MARION COUNTY HEALTH DEPARTMENT
•		0/10/11
•		DATE: 9119114
	••	
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Recommended and Approved By:		•
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HALL LONG OF THE CO. II. LAD	(for)	
WILLIAM C. VANNESS II, MD		
STATE HEALTH COMMISSIONER		
INDIANA STATE DEPARTMENT OF HEALTH		•
DATE: LO/1/11		
DATE:	_	
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Approved:		Approved:
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FORM POPERTON COMMENTS	(for)	(for)
JESSICA ROBERTSON, COMMISSIONER		BRIAN E. BATLEY, OIRECTOR STATE BODGET AGENCY
DEPARTMENT OF ADMINISTRATION STATE OF INDIANA		STATE BODGET AGENCY STATE OF INDIANA
• v —		STATE OF INDIANA
DATE: 19/6/14		DATE: /0/8/14
DATE.		DATE: TO JUJIA
		•
Approved as to Form and Legality:	•	*
Iniua Ssembiosti		
Journa 2 Juniosia	(for)	
GREGORY F. ZOELLER		
ATTORNEY GENERAL OF INDIANA		•
DATE: IOLIVIUI		

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.			

D	10	T	100000000000000000000000000000000000000
Programs and seminars attended by the	Services to be provided		
CHWs will have a TB/HIV element.	in accordance with the		
HIV counseling and testing will be	Tuberculosis Control	j	
offered to clients followed through this	Program Objectives and		
project.	Protocols as evidenced		
	by the quarterly report.		
	Payment will be held		
	until reports are		
	submitted.		
Activities shall supplement, not supplant	Services to be provided]	
the local TB activities necessary for case	in accordance with the		
management, control and prevention of	Tuberculosis Control		
TB in the designated area.	Program Objectives and]	計画は、約5億 。 第一度で数
	Protocols as evidenced		
	by the quarterly report.		
	Payment will be held		Ans n. Mark #
	until reports are		1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
Each CHW will submit The Tuberculosis	submitted.		19 % 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	All reports are due by the 10 th of the month	ļ	
Outreach Quarterly Report (See			
ATTACHMENT B) to the MCHD TB	following the end of	į	
Program Coordinator and the local	each quarter.		
supervisor who will sign and address any	April 10, 2014	Í	
barriers or problems encountered. A copy of the Report should be sent to the State	July 10, 2014 October 10, 2014	1	
TB Control Program.	December 31, 2014		
The TB outreach services provided	Services to be provided		
through this Grant Agreement shall be in	in accordance with the		
accordance with Tuberculosis Program	Tuberculosis Control		
Objectives established by the Indiana	Program Objectives and		
State Department of Health (See	Protocols as evidenced		
ATTACHMENT C).	by the quarterly report.		
	Payment will be held		
	until reports are		
	submitted.		
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meeting for the CHWs and one Regional meeting during the Grant Agreement Period. Attendance is required. In accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced by the quarterly report. Payment will be held until reports are submitted. Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols as evidenced with the Tuberculosis Control Program Objectives and Protocols and Protocols as evidenced by the quarterly report. Each CHW must complete, or show proof of having completed, an approved course in HIV Prevention Counseling. Each CHW should be available on an asneeded basis to assist in outbreak situations in other geographical areas of the State. Each CHW should be available on an asneeded basis to assist in outbreak situations in other geographical areas of the State. Each CHW should be available on an asneeded by the quarterly report. Payment will be held until reports are submitted. 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. 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 Fringe Benefits 33,986.00 23,919.00 24770.00 Total Grant Agreement Stats, 2526.00 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. Salary Costs Fringe Benefits 33,986.00 2,979.00 2,979.00 3,960.00 3,979.00 3,960.00 3,979.00 3,960.00 3,979.00 3,960.00 3,979.00 3,979.00 3,979.00 3,979.00	There will be one Outreach Worker	Services to be provided	T	<u> </u>	
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	Total Grant Agreement		\$135,326.00	\$95,424.00	\$39,902
Total Grant (rounded) \$135,326.00 \$95,424.00 \$395			\$135,326.00		\$39,902

- Salary: Three Community Outreach Workers for twelve months @\$97,380
 - o J. Hare @ \$32,012
 - o R. Cotterman @ \$33,755
 - o 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.