16387

MAY 20 2011

EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-06)

Received
MAY 23 2011
IDOA Contracts

Instructions for completing the EDS and the Contract process.

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.

7/8

1. EDS Number:	2. Date prepared:
A70-1-106039	3/15/2011 PT

3. CONTRACTS & LEASES

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

FISCAL INFORMATION

4. Account Number:	5. Account Name:
15960-94000.573100	CHRONIC DISEASES
6. Total amount this action: $44,275.00	7.New contract total: $62,924.00
8. Revenue generated this action: $0.00	9.Revenue generated total contract: $0.00

10.New total amount for each fiscal year :

Year 2011 $62,924.00
Year ____ $____
Year ____ $____
Year ____ $____

TIME PERIOD COVERED IN THIS EDS

11. From (month, day, year):	12. To (month, day, year):
1/1/2011	6/30/2011

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	0000014068

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 #:
Joe Olivadoti	317-233-7573

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

VENDOR INFORMATION

23 Vendor ID # 0000003310

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

26. Address: MARION COUNTY
3838 N RURAL STREET
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	30. If yes, list the %:
Minority: ___ Yes X No	Minority: ____ %
Women: ___ Yes X No	Women: ____ %
31 Sub Vendor:M/WBE	32. If yes, list the %:
Minority: ___ Yes X No	Minority: ____ %
Women: ___ Yes X No	Women: ____ %
33. Is there Renewal Language in the document? X Yes ___ No	34. Is there a "Termination for Convenience" clause in the document? 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.)*

Amendment #1 will add $44,275 to continue to provide resources to help contain the homeless TB outbreak in Marion County. Funds will be provided for a full-time community health worker and part-time TB Case Manager, to continue working with directly observed therapy, rent/housing assistance, incentives/enablers to ensure completion of treatment, ongoing targeted testing of residents at homeless shelters and special events such as Indy Connect.

38. Justification of vendor selection and determination of price reasonableness:
This vendor is centrally located in the city being served.

RECEIVED
MAY 26 2011
OAG-ADVISORY

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

40. Agency fiscal officer or representative approval	41. Date Approved	42. Budget agency approval	43. Date Approved
	5-18-11		05/25/11
44.Attorney General's Office approval	45. Date Approved	46. Agency representative receiving from AG	47. Date Approved
PRT	6/1/2011		

53456-001

15960-573100-Statefunds
SCD 198-1

Amendment No. 1
EDS Number A70-1-106039

This is an Amendment to the existing **State Chronic Diseases** 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 d.b.a. Marion County Health Department** (hereinafter referred to as the "Grantee") for the period from **January 1, 2011** through **June 30, 2011**, in the amount of **$18,649**.

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 **$44,275** making the new total of the Grant Agreement **$62,924**. The additional funds will be used to **continue providing resources to help contain the homeless TB outbreak in Marion County; to provide for a full-time community health worker and part-time TB Case Manager; to continue working with directly observed therapy, rent/housing assistance, incentives/enablers to ensure completion of treatment, ongoing targeted testing of residents at homeless shelters and special events such as Indy Connect**. See Attachment A-1, attached hereto, which replaces Attachment A, and 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
D.B.A. MARION COUNTY HEALTH DEPARTMENT

DATE: 5-13-11

Accepted By:

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

DATE: 5/5/11

Certification of Funds:

ALLEN L. COLLIER
DIRECTOR OF FINANCE
DIVISION OF FINANCE
OPERATIONAL SERVICES COMMISSION
INDIANA STATE DEPARTMENT OF HEALTH

DATE: 5-18-11

Recommended and Approved By:

MICHAEL R. KISTLER
CHIEF FINANCIAL OFFICER
OPERATIONAL SERVICES COMMISSION
INDIANA STATE DEPARTMENT OF HEALTH

DATE: 5-19-11

Approved:

ROBERT D. WYNKOOP
COMMISSIONER
DEPARTMENT OF ADMINISTRATION
STATE OF INDIANA

DATE: 5/23/11

Approved:

for
ADAM M. HORST, DIRECTOR
STATE BUDGET AGENCY
STATE OF INDIANA

DATE: 05/25/2011

Approved as to Form and Legality:

GREGORY F. ZOELLER
ATTORNEY GENERAL OF INDIANA

DATE: 6/1/2011

Attachment A-1
A70-1-106039
Marion County Health Department (MCHD)

PURPOSE OF GRANT AGREEMENT:

The purpose of this grant is to provide resources to help contain the homeless TB outbreak in Marion County. Funds will be provided for a full time community health worker and part-time TB Case Manager, rent/housing assistance, incentives/enablers to ensure completion of treatment, ongoing targeted testing of residents at homeless shelters and special events such as Indy Connect.

SERVICE RECIPIENTS:

TB suspects/cases in Marion County, especially those who are homeless.

CONSIDERATION FOR DELIVERABLES AND SCHEDULE OF PAYMENT:

REQUIRED ACTIVITIES	MEASURABLE CRITERIA	Budgeted Amount	SCHEDULE OF PAYMENT
One (1 FTE) Community Health Worker (CHW) will be responsible for directly observed therapy (DOT) for cases, assist with finding individuals needed for follow up, assist with additional screenings, follow up of additional cases, and work closely with the TB Nurse case manager. One (0.58 FTE) part-time TB nurse Case Manager (23 hrs/wk) to be lead outbreak investigator, provide consistent patient interviewing, and make epi links between cases	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols.	$24,919	Payment shall be due for hours worked, mileage incurred and satisfactory completion of Marion County Health Department (MCH) Deliverables. Such payment shall be paid once monthly in arrears.
Rent/housing assistance for TB cases/suspects in IN074 2009- 12 cases 2010- 10 cases 2011- 1 case (unmatched) 1 suspect	KS- 1 month TC- 3 months LO- 4 months 1 additional x 3 months 11 client-months x $625/month	$6,875	Once monthly in arrears
Incentives/enablers for TB cases/suspects for each month of completion.	$12.50 each x 15 client-months	$200	Once monthly in arrears

REQUIRED ACTIVITIES	MEASURABLE CRITERIA	Budgeted Amount	SCHEDULE OF PAYMENT
Biweekly QFT testing for ongoing targeted testing and surveillance of IN0074 outbreak at Wheeler Lighthouse Mission.	Avg. 20/week x 18 weeks = 360 QFT Tests. $32.50/test	$11,700	Once monthly in arrears
Shared transportation to/from clinic for LTBI and TB clients	Avg. 3/week, round trip x 18 weeks = 36; $20 round trip	$720	Once monthly in arrears
Targeted Testing event using QFT at Indy Connect, April 13, 2011	150 clients x $32.50	$4,875	Once monthly in arrears
Incentives for Indy Connect event for result return	150 clients x $4/ bus pass	$600	Once monthly in arrears
June: 6 month repeat of shelter testing using QFT	130 clients x $32.50	$4,225	Once monthly in arrears
A Marion County Health Department TB staff will submit a quarterly report which will include a summary or *The Tuberculosis Outreach Quarterly Report* (see ATTACHMENT B) for the outreach workers, progress towards treatment completion of TB cases and LTBI cases, other activities and expenditures to the TB/Refugee Health Division.	All reports are due by the 10th of the month following the end of each quarter.		Payment shall be due for hours worked and satisfactory completion of MCHD deliverables. Such payment shall be paid once monthly in arrears.
The TB outreach services provided through this Grant Agreement shall be in accordance with the *Statewide and Marion County Tuberculosis Program Objectives and* (See ATTACHMENT C).			
Attendance at the 2011 TB Symposium.	Services to be provided in accordance with the Tuberculosis Control Program Objectives and Protocols.		Payment shall be due for satisfactory completion of MCHD deliverables. Such payment shall be paid once monthly in arrears.
Total Salary & Other Costs		$24,919.00	
Benefits		$8,010.00	
Travel		800.00	
Rent/Housing		6,875.00	
Incentives/Enablers		1,520.00	
Target Testing with IGRA		20,800.00	
Total Grant Agreement		$62,924.00	

Salary: One full-time community outreach worker (Earl Murphy) for six months from January 1, 2011 to June 30, 2011 = $13,319
Benefits: FICA, PERF, and Insurance =$4,530
One part-time (.58) TB case manager for 4 months from March 1, 2011 to June 30, 2011 = $11,600
Benefits: FICA, PERF, and Insurance = $3,480.

ASSOCIATED DELIVERABLES

- **Travel:**
  Travel expenditures will be reimbursed by the State at the rate customarily paid by the Grantee or the current rate of $.40/mile being paid by the State of Indiana, whichever is the lesser. 2000 miles x $.40 = $800

- **Invoices:**
  All invoices must be 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 invoices provided by the State.