

12353

MAY 09 2008



# EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-06)

Instructions for completing the EDS and the Contract process.

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

IDOA Contracts

6/30

PT

|                                |                                |
|--------------------------------|--------------------------------|
| 1. EDS Number:<br>A70-8-069134 | 2. Date prepared:<br>3/18/2008 |
|--------------------------------|--------------------------------|

## 3. CONTRACTS &amp; LEASES

|   |  |
|---|--|
| Professional/Personal Services            | Contract for procured Services                   |
| <input checked="" type="checkbox"/> Grant | Maintenance                                      |
| Lease                                     | License Agreement                                |
| Attorney                                  | <input checked="" type="checkbox"/> Amendment# 1 |
| MOU                                       | Renewal #  |
| QPA                                       | Other  |

## FISCAL INFORMATION

|   |  |
|---|--|
| 4. Account Number:<br>3610-10333            | 5. Account Name:<br>Dental Services for Aging  |
| 6. Total amount this action:<br>\$52,000.00 | 7. New contract total:<br>104,000.00           |
| 8. Revenue generated this action:<br>\$0.00 | 9. Revenue generated total contract:<br>\$0.00 |
| 10. New total amount for each fiscal year:  |  |
| Year 2008                                   | \$52,000.00                                    |
| Year 2009                                   | \$52,000.00                                    |
| Year  | \$   |
| Year  | \$   |

## TIME PERIOD COVERED IN THIS EDS

|  |   |
|--|---|
| 11. From (month, day, year):<br>1/12/2008      | 12. To (month, day, year):<br>6/30/2009 |
| 13. Method of source selection:                |   |
| <input checked="" type="checkbox"/> Negotiated |   |
| <input type="checkbox"/> Bid/Quotation         |   |
| <input type="checkbox"/> Emergency             |   |
| <input type="checkbox"/> Special Procurement   |   |
| <input type="checkbox"/> RFP#                  |   |
| <input type="checkbox"/> Other (specify)       |   |

| AGENCY INFORMATION  |                         |
|---|-------------------------|
| 14. Name of agency:<br>Department of Health                 | 15. Requisition Number: |
| 16. Address: 2 N. Meridian Street<br>Indianapolis, IN 46204 |                         |

| AGENCY CONTACT INFORMATION               |                                  |
|--|----------------------------------|
| 17. Name:<br>Rita Hope                   | 18. Telephone #:<br>317.233.9256 |
| 19. E-mail address:<br>rhohe@isdh.in.gov |                                  |

| COURIER INFORMATION                        |                                  |
|--|----------------------------------|
| 20. Name:<br>Steve Martin                  | 21. Telephone #:<br>317.233.7573 |
| 22. E-mail address:<br>smartin@isdh.in.gov |                                  |

| VENDOR INFORMATION   |                                  |
|--|----------------------------------|
| 23. Vendor ID # 0000078886   |                                  |
| 24. Name:<br>INDIANA FOUNDATION OF DENTISTRY F/T HAN                                     | 25. Telephone #:<br>317.631.6022 |
| 26. Address: DENTISTRY FOR THE HANDICAPPED<br>1800 15TH ST. UNIT 100<br>DENVER, CO 80202 |                                  |
| 27. E-mail address: fleviton@nfdh.org  |                                  |

|  |  |
|--|--|
| 28. Is the vendor registered with the Secretary of State? (Out of State Corporations must be registered) |  |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                      |  |
| 29. Primary Vendor: M/WBE  | 30. If yes, list the %:  |
| Minority: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                            | Minority: %  |
| Women: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                               | Women: %   |
| 31. Sub Vendor: M/WBE  | 32. If yes, list the %:  |
| Minority: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                            | Minority: %  |
| Women: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                               | Women: %   |
| 33. Is there Renewal Language in   | 34. Is there a "Termination for Convenience" clause in the document? |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |

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

36. Statutory Authority (Cite applicable Indiana or Federal Codes):  
NONE

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

This line item appropriation was authorized by the General Assembly to address a need for access to dental care for the elderly and disabled population whose needs are not being met by existing public assistance. Amendment #1 extends the grant through FY 2009 with \$52,000.

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

Indiana Donated Dental Services (IDDS) operates a highly efficient system for delivery of oral health services. IDDS utilizes volunteer dentists and laboratories to deliver much needed services to handicapped individuals who would not otherwise receive treatment.

RECEIVED

MAY 16 2008

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<br>MTR | 41. Date Approved<br>5/8/08    | 42. Budget agency approval<br>Michael F. Compton | 43. Date Approved<br>5/13/08 |
| 44. Attorney General's Office approval<br>PORT              | 45. Date Approved<br>5/27/2008 | 46. Agency representative receiving from AG      | 47. Date Approved            |

23648-001

JDP

**Amendment No. 1**  
**EDS Number A70-8-069134**

This is an Amendment to the existing Dental Services for the Handicapped & Aging Grant Agreement entered into by and between the **Indiana State Department of Health** (hereinafter referred to as the "State") and **Indiana Foundation of Dentistry For The Handicapped, Inc.** (hereinafter referred to as the "Grantee") for the period from January 12, 2008 through June 30, 2008, in the amount of \$52,000.

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 \$52,000 making the new total of the Grant Agreement \$104,000. The additional funds will be used to provide access to dental care for the elderly and disabled population whose needs are not being met by existing public assistance. See Attachment B, attached hereto, made a part hereof and incorporated herein as part of this Grant Agreement. The expiration date of this Grant Agreement is being extended to June 30, 2009.

The following paragraph replaces the previous Grant Agreement paragraph:

**10. Compliance with Laws**

B. The Grantee and its agents shall abide by all ethical requirements that apply to persons who have a business relationship with the State as set forth in IC § 4-2-6 *et seq.*, IC § 4-2-7, *et seq.*, the regulations promulgated there under, and Executive Order 04-08, dated April 27, 2004. If the Grantee is not familiar with these ethical requirements, the Grantee should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission website at <http://www.in.gov/ethics/>. If the Grantee or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Grant immediately upon notice to the Grantee. In addition, the Grantee may be subject to penalties under IC §§ 4-2-6, 4-2-7, 35-44-1-3, and under any other applicable laws.

Paragraph 20A – **Additional Payment Terms** is amended to read:

The State disburses Grant funds on a cost reimbursement basis. Actual expenditures of authorized costs will be reimbursed monthly by the State upon receipt of duly executed Invoices from the Grantee. Invoices shall be due by the 20<sup>th</sup> day after the end of each month. Payments shall not exceed \$52,000 for the period of January 12, 2008 through June 30, 2008, and \$52,000 for the period July 1, 2008 through June 30, 2009. Total remuneration under this Grant Agreement shall not exceed \$104,000.

Paragraph 20B is amended to read:

All accounts will be closed sixty (60) days after the end of each Grant Agreement period as specified in Paragraph 20A. Any invoice submitted after sixty (60) days will not be reimbursed by the State.

#### **Funding Summary**

|             |                        |               |
|-------------|------------------------|---------------|
| 3610-103330 | 01/12/08 thru 06/30/08 | \$ 52,000     |
| 3610-103330 | 07/01/08 thru 06/30/09 | <u>52,000</u> |
| Total       |                        | \$104,000     |

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.**

**ATTACHMENT B - DSHA 949-2 – FY 2009 \$52,000  
A70-8-069134**

The Indiana State Department of Health, Oral Health Program, a section of Maternal Child Health Services, is awarding the NATIONAL FOUNDATION OF DENTISTRY FOR THE HANDICAPPED- INDIANA DONATED DENTAL SERVICES these monies to provide referral assistance to disabled, aged or residents of Indiana, unable to afford dental care nor get help through public aid—people with seriously neglected problems that have no other way of obtaining needed care.

Indiana Donated Dental Services will provide to the Indiana State Department of Health (ISDH) Oral Health Program Director:

Quarterly reports with non identifying demographical data on numbers and ages of patients served, descriptions of services, logistical data on cities or counties (urban or rural) where services were provided, including provider zip codes, if possible.

Quarterly reports will also include the cost of operations for the Indiana Donated Dental Services including specifics relating to this particular grant.

An annual report will be submitted to ISDH in addition to the quarterly reports with summaries of data collected and a brief program narrative on progress for each year of the contract. Comparisons may be made from previous years' growth and activities. A list of provider dentists with contact information should accompany the annual report. If possible, an estimate of actual costs of services (if fees would have been charged) would be appreciated for ISDH cost savings data collection bank.

Invoices will be submitted monthly in arrears, according to the ISDH required formats.

(See Program Manager for details. Ms. Rita Hope [rhope@isdh.in.gov](mailto:rhope@isdh.in.gov) 317 233 9256)

| Anticipated Expenditures for Fiscal Year 2009 7/1/2008 to 6/30/2009 |   |               |                      |                                |        |        |
|---|---|---------------|----------------------|--------------------------------|--------|--------|
|   | Indiana Foundation of Dentistry For<br>The Handicapped - Donated Dental<br>Services Program | DD 949-1      | MOU<br>DSHA<br>949-2 | Other<br>funding -<br>Non ISDH | Total  |        |
|   | <b>Schedule A</b>   |               |                      |                                |        |        |
| 111   | Physicians  |               |                      |                                |        |        |
| 111.15  | Dentists/Hygienists   |               |                      |                                |        |        |
| 111.2   | Other Service Providers   |               |                      |                                |        |        |
| 111.35  | Care Coordination   |               |                      |                                |        |        |
| 111.4   | Nurses  |               |                      |                                |        |        |
| 111.6   | Social Service Providers  |               |                      |                                |        |        |
| 111.7   | Nutritionists/Dieticians  |               |                      |                                |        |        |
| 111.8   | Medical/Dental/Project Director   |               |                      |                                |        |        |
| 111.825   | Project Coordinator   |               | 40181                | 15071                          | 55252  | note a |
| 111.85  | Other Administration  | 17482         | 2518                 |                                | 20000  | note b |
| 115   | Fringe Benefits   |               | 9301                 | 12905                          | 22206  | note c |
|   | <b>Schedule B</b>   |               |                      |                                |        |        |
| 200   | Contractual Services  | 1400          |                      |                                | 1400   |        |
| 200.5   | Equipment   |               |                      |                                | 0      |        |
| 200.6   | Consumable Supplies   | 11050         |                      |                                | 11050  |        |
| 200.7   | Travel  | 3200          |                      |                                | 3200   |        |
| 200.8   | Rental and Utilities  | 700           |                      |                                | 700    |        |
| 200.85  | Communications  | 4200          |                      |                                | 4200   |        |
| 200.9   | Other Expenditures  | 4900          |                      |                                | 4900   |        |
|   | <b>Subtotal Schedule A</b>  | 17482         | 52000                | 27976                          | 97458  |        |
|   | <b>Subtotal Schedule B</b>  | 25450         |                      |                                | 25450  |        |
|   | <b>Total</b>  | 42932         | 52000                | 27976                          | 122908 |        |
|   |   |               |                      |                                |        |        |
|   | <b>Calculations - rounded up</b>  |               |                      |                                |        |        |
| note a  | Project Coordinator   | 18.29*32*52   |                      | 30434.56                       |        |        |
|   |   | 14.914*32*52  |                      | 24816.9                        | 55252  |        |
| note b  | Other Administration  | \$48.077*8*52 |                      |                                | 20000  |        |
| note c  | Fringe Benefits   | 55252*.401904 |                      |                                | 22206  |        |
|   |   |               |                      |                                |        |        |
|   |   |               |                      |                                |        |        |
|   |   |               |                      |                                |        |        |

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:**



FRED LEVITON  
VP/CHIEF OPERATING OFFICER  
INDIANA FOUNDATION OF DENTISTRY FOR THE  
HANDICAPPED

DATE: 4/24/08

**Certification of Funds:**



BEVERLY S. FLANAGAN  
DEPUTY DIRECTOR OF BUSINESS PROCESSES  
DIVISION OF FINANCE  
OPERATIONAL SERVICES COMMISSION  
INDIANA STATE DEPARTMENT OF HEALTH

DATE: May 8, 2008

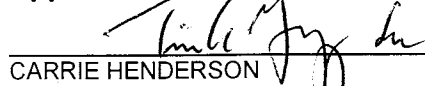
**Recommended and Approved By:**



LANCE RHODES  
CHIEF FINANCIAL OFFICER  
OPERATIONAL SERVICES  
INDIANA STATE DEPARTMENT OF HEALTH

DATE: 5/8/08

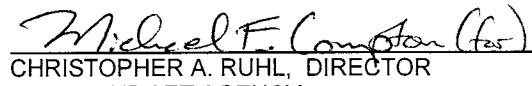
**Approved:**



CARRIE HENDERSON  
COMMISSIONER  
DEPARTMENT OF ADMINISTRATION  
STATE OF INDIANA

DATE: 5/12/08

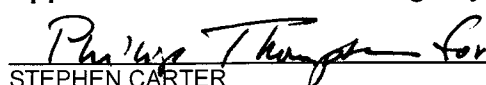
**Approved:**



CHRISTOPHER A. RUHL, DIRECTOR  
STATE BUDGET AGENCY  
STATE OF INDIANA

DATE: 5/13/08

**Approved as to Form and Legality:**



STEPHEN CARTER  
ATTORNEY GENERAL OF INDIANA

DATE: 5/27/2008