

**EXECUTIVE DOCUMENT SUMMARY**

State Form 41221 (R10/4-14)

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.

**Received****AUG 12 ENT'D****DOA Contracts**

EK

p12

MM

1. EDS Number: A70-4-070512	2. Date prepared: 6/27/2014
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**3. CONTRACTS & LEASES**

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

**FISCAL INFORMATION**

4. Account Number: 61900-30700.571100	5. Account Name: ISDH DOAg Fund
6. Total amount this action: \$5,447.94	7. New contract total: 126,395.98
8. Revenue generated this action: \$0.00	9. Revenue generated total contract: \$0.00
10. New total amount for each fiscal year:	
Year 2014	\$120,948.04
Year 2015	\$5,447.94
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 checked="" type="checkbox"/> RFP# 12-50	<input type="checkbox"/> Other (specify) <u>          </u>
<input type="checkbox"/> Negotiated	<input type="checkbox"/> Special Procurement

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.) Contract is being amended to provide personnel, fringe, nutrition education activities, outreach activities, travel and other miscellaneous needs for the agency.
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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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40. Agency fiscal officer or representative approval <i>[Signature]</i>	41. Date Approved 8/11/14	42. Budget agency approval <i>[Signature]</i>	43. Date Approved 8/15/14
44. Attorney General's Office approval	45. Date Approved	46. Agency representative receiving from AG	47. Date Approved

**AGENCY INFORMATION**

14. Name of agency: Department of Health	15. Requisition Number: 0000026212
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16. Address: 2 N. Meridian Street Indianapolis, IN 46204
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**AGENCY CONTACT INFORMATION**

17. Name: Alexander Tulkop	18. Telephone #: 317/233-7458
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19. E-mail address: atulkop1@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 #	0000064075
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24. Name: CLAY COUNTY	25. Telephone #: (812) 448-9021
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26. Address: CLAY COUNTY AUDITOR/TREASURER 608 E NATIONAL AVE RM 105 BRAZIL, IN 47834
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27. E-mail address: joyce@claycountyin.gov
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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
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29. Primary Vendor: M/WBE/IN-Veteran	30. Primary Vendor Percentages
Minority: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	100.0 %
Women: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
IN-Veteran: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

31. Sub Vendor: M/WBE/IN-Veteran	32. If yes, list the %:
Minority: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Minority: <u>          </u> %
Women: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Women: <u>          </u> %
IN-Veteran: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	IN-Veteran: <u>          </u> %

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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**RECEIVED****AUG 16 2014****OAG-ADVISORY**

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.	Date	Required Date	Page
0000026212	07/29/2014		1 of 1
Fund/Account:	61900 / 571100		
Dept Number:	195070		
Project Number:	40010557WICAD14		
Requisition Number:	0000026212		
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 A70-4-070512, 10/1/13-9/30/14	1.0000	LO	5,447.9400	5,447.94

Vendor: 0000064075 CLAY COUNTY

<< PLEASE SEE ATTACHED CONTRACT  
CONTRACT DATE 10/1/13-9/30/14  
CONTRACT AMOUNT \$5,447.94

EXISTING PURCHASE ORDER # 14534213 >>

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

Requisition Total \$ 5,447.94

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

**Amendment No. 1  
EDS Number A70-4-070512 (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 **Clay County Health Department** (hereinafter referred to as the "Grantee") for the period from **October 1, 2013 through September 30, 2014**, in the amount of **\$120,948.04**.

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 **\$5,447.94** making the new total of the Grant Agreement **\$126,395.98**. 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.

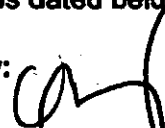
**Non-Collusion and Acceptance**

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:

  
CAMILLO MARK MENDOZA, M.D.  
HEALTH OFFICER  
CLAY COUNTY HEALTH DEPARTMENT

DATE:

7/29/14

Attested By:

  
MARY JO ALUMBAUGH  
AUDITOR  
CLAY COUNTY

DATE:

7/31/14

Recommended and Approved By:

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

(for)

DATE:

8/14/14

Approved:

  
JESSICA ROBERTSON, COMMISSIONER  
DEPARTMENT OF ADMINISTRATION  
STATE OF INDIANA

(for)

DATE:

8/13/14

Approved:

  
BRIAN E. BAILEY, DIRECTOR  
STATE BUDGET AGENCY  
STATE OF INDIANA

(for)

DATE:

8/15/14

Approved as to Form and Legality:

  
GREGORY E. ZOELLER  
ATTORNEY GENERAL OF INDIANA

(for)

DATE:

8/18/14

**Attachment B1 - Budget Summary**



**Indiana State  
Department of Health**

**INDIANA WIC  
Local Agency Budget**

<b>Name of Organization:</b>	Clay County Health Department		
<b>Employer ID Number (EIN)</b>	35-6000133		
<b>Breastfeeding Region</b>	Monroe	<b>Federal Fiscal Year</b>	2014

<b>Address:</b>	1214 East National Avenue #B110		
<b>City:</b>	Brazil	<b>State:</b>	Indiana
<b>Zip:</b>	47834		

<b>Phone:</b>	812-448-9021	<b>Fax:</b>	812-448-9018
<b>Website:</b>			

<b>Name of Chief Executive:</b>	Camillo Mark Mendoza		
<b>Title:</b>	Health Officer	<b>Phone:</b>	812-448-9021
<b>Email:</b>	joyce@claycountyn.in.gov		

<b>Name of Program Contact:</b>	Elizabeth Wheby		
<b>Title:</b>	WIC Coordinator	<b>Phone:</b>	812-442-0573
<b>Email:</b>	claynutrition@gmail.com		

<b>Clinic Operation Caseload</b>	892	<b>Breastfeeding Promotion Caseload</b>	99
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<b>WIC Nutrition Services &amp; Admin (NSA) Total Costs:</b>	<b>\$ 126,395.98</b>
<b>Breastfeeding Promotion Costs:</b>	<b>\$ 3,576.32</b>
Personnel - Salary:	\$ 2,605.16
Personnel - Fringe:	\$ 795.16
Travel:	\$ 176.00
<b>Clinic Operations Costs:</b>	<b>\$ 122,819.66</b>
Personnel - Salary:	\$ 80,128.72
Personnel - Fringe:	\$ 27,140.17
Travel - Clinic Services:	\$ 496.32
Travel - Nutrition Education:	\$ -
Supplies:	\$ 3,803.05
Communication:	\$ 1,684.00
Contract Services:	\$ 1,167.40
Space Costs:	\$ 8,400.00