

15727

OCT 01 2010



EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-06)

Received

Instructions for completing the EDS and the Contract process.

OCT 05 2010

IDOA 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.

1. EDS Number: A70-0-106032		2. Date prepared: 8/31/2010	
3. CONTRACTS & LEASES			
<input checked="" type="checkbox"/> Professional/Personal Services <input checked="" type="checkbox"/> Grant <input type="checkbox"/> Lease <input type="checkbox"/> Attorney <input type="checkbox"/> MOU <input type="checkbox"/> QPA		<input type="checkbox"/> Contract for procured Services <input type="checkbox"/> Maintenance <input type="checkbox"/> License Agreement <input checked="" type="checkbox"/> Amendment# 1 <input type="checkbox"/> Renewal # <input type="checkbox"/> Other	
FISCAL INFORMATION			
4. Account Number: 61910-94000.573100		5. Account Name: ISDH DHHS Fund	
6. Total amount this action: \$10,190.00		7. New contract total: 119,982.00	
8. Revenue generated this action: \$0.00		9. Revenue generated total contract: \$0.00	
10. New total amount for each fiscal year:			
Year 2010 \$119,982.00			
Year \$			
Year \$			
Year \$			
TIME PERIOD COVERED IN THIS EDS			
11. From (month, day, year): 1/1/2010		12. To (month, day, year): 12/31/2010	
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)			
35. Will the attached document involve data processing or telecommunications systems(s)? <input type="checkbox"/> 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 is to add \$10,190 for the current period due to Marion County having 50% of all active tuberculosis cases in the state for 2010. To provide directly observed therapy services and directly observed preventive therapy for high-risk contacts, augmenting the TB services available in Marion County.			
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.			
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 10/1/10	
44. Attorney General's Office approval 		45. Date Approved 10/15/10	
42. Budget agency approval 		43. Date Approved 10/13/10	
46. Agency representative receiving from AG		47. Date Approved	

44180-001

RECEIVED

OCT 15 2010

OAG-ADVISORY

**Amendment No. 1
EDS Number A70-0-106032**

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 d.b.a. Marion County Health Department** (hereinafter referred to as the "Grantee") for the period from January 1, 2010 through December 31, 2010, in the amount of \$109,792.

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 \$10,190 making the new total of the Grant Agreement \$119,982. The additional funds will be used to continue providing directly observed therapy services and directly observed preventive therapy for high-risk contacts, augmenting the TB services available in Marion County. 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:

9/28/10

Accepted By:



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

DATE:

9/23/10

Certification of Funds:

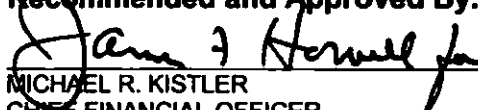


ALLEN L. COLLIER
DIRECTOR OF FINANCE
DIVISION OF FINANCE
OPERATIONAL SERVICES COMMISSION
INDIANA STATE DEPARTMENT OF HEALTH

DATE:

10/1/10

Recommended and Approved By:



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

DATE:

10/1/10

Approved:



ROBERT D. WYNKOOP
COMMISSIONER
DEPARTMENT OF ADMINISTRATION
STATE OF INDIANA

DATE:

10/5/10

Approved:

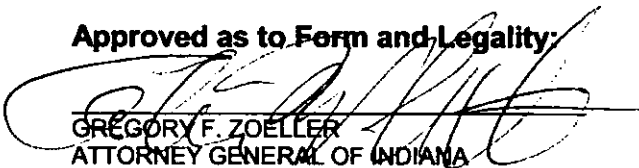


ADAM M. MORISY, DIRECTOR
STATE BUDGET AGENCY
STATE OF INDIANA

DATE:

10/13/10

Approved as to Form and Legality:



GREGORY F. ZOELLER
ATTORNEY GENERAL OF INDIANA

DATE:

10/15/10

Attachment A-1
A70-0-106032
Marion County 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.

SERVICE RECIPIENTS:

Individuals living in Marion County.

CONSIDERATION FOR DELIVERABLES AND SCHEDULE OF PAYMENT:

REQUIRED ACTIVITIES	MEASURABLE CRITERIA	ANNUAL RATE FY 2007	SCHEDULE OF PAYMENT
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.	\$94,466	Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
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.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.

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..		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
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.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Each CHW will submit <i>The Tuberculosis Outreach Quarterly Report</i> (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 10 th of the month following the end of each quarter. April 10, 2010 July 10, 2010 October 10, 2010 January 10, 2011		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department 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 <i>Tuberculosis Program Objective</i> and policies 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.		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.

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..	\$440	Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Each CHW must complete, or show proof of having completed, an approved course in <i>HIV Prevention Counseling</i> .	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..		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
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..		Payment shall be due for hours worked and satisfactory completion of Marion County Health Department Deliverables. Such payment shall be paid once monthly in arrears.
Total Salary Costs			\$94,466
Fringe Benefits			\$ 25,076
Travel & Training			\$ 440
Total Grant Agreement			\$119,982

- **Salary:** Three Community Outreach Workers for twelve months @\$94,466
 - P. Gray @ \$31,885
 - A. Cotterman @ \$30,696
 - K. Wilcox @ \$ 31,885

- **Fringe Benefits @ 29.6% of original grant salaries = \$25,076**

- **Travel & Training: \$440**

In-State Travel and Training expenditures, registration, lodging etc. 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:**

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 invoice.