

20456

SEP 24 2014



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 type all information.
 3. Check all boxes that apply.
 4. For amendments / renewals, attach original contract.
 5. Attach additional pages if necessary.

Received

SEP 24 2014

DOA Contracts

11/14

AO

1. EDS Number: A70-4-070537	2. Date prepared: 8/30/2014
3. CONTRACTS & LEASES	
<input 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# <u>1</u> <input type="checkbox"/> Renewal # <input type="checkbox"/> Other
FISCAL INFORMATION	
4. Account Number: 61900-30700.583110	5. Account Name: ISDH DOAg Fund
6. Total amount this action: \$8,046.18	7. New contract total: 83,206.58
8. Revenue generated this action: \$0.00	9. Revenue generated total contract: \$0.00
10. New total amount for each fiscal year:	
Year 2014	\$75,160.40
Year 2015	\$8,046.18
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 type="checkbox"/> Negotiated <input checked="" type="checkbox"/> RFP# 12-50 <input type="checkbox"/> Other (specify) <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	
36. Statutory Authority (Cite applicable Indiana or Federal Codes): 42 U.S.C. 1786	
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.	
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.	
39. If this contract is submitted late, please explain why: (Required if more than 30 days late.)	
40. Agency fiscal officer or representative approval <i>[Signature]</i>	
41. Date Approved 9/23/14	
42. Budget agency approval <i>[Signature]</i>	
43. Date Approved 9/29/14	
44. Attorney General's Office approval <i>[Signature]</i>	
45. Date Approved 9/30/14	
46. Agency representative receiving from AG	
47. Date Approved	

AGENCY INFORMATION	
14. Name of agency: Department of Health	15. Requisition Number: 0000026299
16. Address: 2 N. Meridian Street Indianapolis, IN 46204	
AGENCY CONTACT INFORMATION	
17. Name: Steven A. Gale	18. Telephone #: 317/233-9243
19. E-mail address: sgale1@isdh.in.gov	
COURIER INFORMATION	
20. Name: Michael P. Mendyk	21. Telephone #: 317-233-7853
22. E-mail address: mmendyk@isdh.in.gov	
VENDOR INFORMATION	
23. Vendor ID # 0000057650	25. Telephone #: (574) 772-7918
24. Name: STARKE COUNTY	26. Address: STARKE COUNTY HIGHWAY 3839 E 250 N KNOX, IN 46534
27. E-mail address: T.BrowneMD@ipb.org	
28. Is the vendor registered with the Secretary of State? (Out of State Corporations, must be registered) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
29. Primary Vendor: M/WBE/IN-Veteran Minority: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Woman: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> IN-Veteran: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	30. Primary Vendor Percentages 100.0 %
31. Sub Vendor: M/WBE/IN-Veteran Minority: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Women: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> IN-Veteran: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	32. If yes, list the % Minority: _____ % Woman: _____ % IN-Veteran: _____ %
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

RECEIVED

SEP 30 2014

OAG-ADVISORY



73987-001

lw

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
0000026299	08/06/2014		1 of 1
Fund/Account:	61900 / 571100		
Dept Number:	195070		
Project Number:	40010557WICAD14		
Requisition Number:	0000026299		
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
Contract is being amended to provide personnel, fringe, nutrition education activities, outreach activities, travel and other miscellaneous needs for the agency. 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 A70-4-070537, 10/1/13-9/30/14	1.0000	LO	8,046.1800	8,046.18

Vendor: 0000057650 STARKE COUNTY

<< PLEASE SEE ATTACHED CONTRACT
CONTRACT DATE 10/1/13-9/30/14
CONTRACT AMOUNT \$8,046.18

EXISTING PURCHASE ORDER # 14534295 >>

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

Requisition Total \$ 8,046.18

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

61900-571100-40010557WICAD14
WIC

**Amendment No. 1
EDS Number A70-4-070537**

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 **Starke County Health Department** (hereinafter referred to as the "Grantee") for the period from **October 1, 2013** through **September 30, 2014**, in the amount of **\$75,160.40**.

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 **\$8,046.18** making the new total of the Grant Agreement **\$83,206.58**. 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.

Paragraph 5A – Grant Funding is amended to read:

The State shall fund this grant in the amount of **\$83,206.58**. The approved Project Budget is set forth in **Attachment B-1** of this Grant Agreement, attached hereto and incorporated herein. The Grantee shall not spend more than the amount for each line item in the Project Budget without the prior written consent of the State, nor shall the Project costs funded by this Grant Agreement and those funded by any local and/or private share be changed or modified without the prior written consent of the State.

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:

Thomas Browne M.D.

THOMAS BROWNE, M.D.
HEALTH OFFICER
STARKE COUNTY HEALTH DEPARTMENT

DATE: 9/12/14

Attested By:

Katherine Chaffins

KATHERINE CHAFFINS
AUDITOR
STARKE COUNTY

DATE: 9/15/14

Recommended and Approved By:

William C. Vanness II, MD (for)
WILLIAM C. VANNESS II, MD
STATE HEALTH COMMISSIONER
INDIANA STATE DEPARTMENT OF HEALTH

DATE: 9/23/14

Approved:

Jessica Robertson (for)
JESSICA ROBERTSON, COMMISSIONER
DEPARTMENT OF ADMINISTRATION
STATE OF INDIANA

DATE: 9/25/14

Approved:

Brian E. Bailey (for)
BRIAN E. BAILEY, DIRECTOR
STATE BUDGET AGENCY
STATE OF INDIANA

DATE: 9/29/14

Approved as to Form and Legality:

Gregory F. Zoeller (for)
GREGORY F. ZOELLER
ATTORNEY GENERAL OF INDIANA

DATE: 9-30-14

Attachment B1 - Budget Summary



**Indiana State
Department of Health**

**INDIANA WIC
Local Agency Budget**

Name of Organization:	Starke County Health Department		
Employer ID Number (EIN)			
Breastfeeding Region	White	Federal Fiscal Year	2015

Address:	Starke County Courthouse, Washington Street		
City:	Knox	State:	Indiana
Zip:	46534		

Phone:	(574) 772-2175	Fax:	(574) 772-2764
Website:			

Name of Chief Executive:	Thomas Browne, MD		
Title:	Health Officer	Phone:	(574) 772-7918
Email:	T.BrowneMD@lph.org		

Name of WIC Coordinator:	Jennifer Salyer, RN		
Title:		Phone:	
Email:			

Clinic Operation Caseload	717	Breastfeeding Promotion Caseload	98
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WIC Nutrition Services & Admin (NSA) Total Costs:	\$ 83,206.58
Breastfeeding Promotion Costs:	\$ 2,385.21
Personnel - Salary:	\$ 1,900.08
Personnel - Fringe:	\$ 312.65
Travel:	\$ 172.48
Clinic Operations Costs:	\$ 80,821.37
Personnel - Salary:	\$ 48,318.52
Personnel - Fringe:	\$ 16,611.27
Travel - Clinic Services:	\$ 256.60
Travel - Nutrition Education:	\$ -
Supplies:	\$ 2,107.98
Communication:	\$ 2,200.00
Contract Services:	\$ 1,103.00
Space Costs:	\$ 10,224.00