

Warren County Health Services Committee Meeting
Additional Agenda Item
September 25, 2009

Request Resolution:

To enter into a contract agreement with New York State Department of Health to accept funding for the WIC Program for the contract year in the amount of \$549,953 for the contract year October 1, 2009 – September 30, 2010.

Rationale:

Contracts were very late this year throughout the entire state. Finally, last week, after a lot of extra calling, and e-mailing, including the efforts of our own BOS Chairman, Mr. Monroe, we were notified of our grant award. Last evening, the contract was actually received and this year will be submitted and handled electronically.

**Warren County Health Services
Health Services Committee Meeting Agenda
September 25, 2009
Information Submitted By: Patricia Auer, DPH/DPS**

Pending Items

Prospect Child and Family Center Contract

We have no information to report this month.

New Business

Seven County Diabetes Network

We received \$1,000 in Health Education revenue from Glens Falls Hospital on behalf of this coalition, with the provision that at least two groups are provided with a short summary of the mission and the work of this initiative. Of special interest to the group is to have the presentation made to individuals with legislative connections – hence our Health Services Committee fit the bill. So we are able to fulfill our obligation, Dan Durkee, our Health Educator, will be present at the meeting to provide the information. He also provided information to our Professional Advisory Committee, and to the Warren County School Nurses.

Question for the Committee:

At the July 24, 2009 meeting, approval was received to enter into an agreement to accept grant funding from New York State Department of Health for a non - competitive grant for the period August 1, 2009 through March 31, 2010, in the amount of \$34,000. The purpose of the grant is to develop a local action plan to implement policy and environmental changes to address the physical activity and nutrition objectives in the Department of Health's Prevention Agenda.

In the past few weeks, as more information has been received regarding the deliverables for this grant, it has become quite clear that this short term initiative will require a good deal of work on the part of our Health Educator. In light of the upcoming anticipated busy H1N1 season and the need for extra public presentations and public education efforts with no additional resources, we do not have staff time to spare. Several local counties have opted out, and decided not to tackle this grant. Upper Hudson Primary Care Consortium has offered and is willing to assist, but we would need to subcontract with them to handle the activities and planning efforts. This would eat up the majority of the grant funds, and we would still need to contribute Health Educator time. Also, the timing for receipt of the funding is up in the air as the state is not committal as to when the contracts will be ready, and then after the contracts are executed, when the funds will actually be dispersed. Additionally, the contract is up on March 31, 2010, and monies must be spent by then. Upper Hudson is willing to do work and not receive payment until the funds are received, and we always hate not to accept grants when they are offered, but the timing, commitment, and questions regarding what types of plans will be accepted for funding, as well as the fact that tangible anticipated gains for this project will be minimal, and really could be accomplished anyway with our ongoing involvement with the Rural Health Network and the Community Health Assessment Project.

We will do whatever the committee wishes, but my recommendation is to pass on this one.

Request Resolution:

To renew the grant with New York State Department of Health to allow receipt of funding for the Children With Special Health Care Needs Program in the amount of \$18,505 for the contract year October 1, 2009 through September 30, 2010.

Rationale:

This is a grant the department receives annually. It assists with covering the salary of the nurse assigned to the Child Find Program in the Family Health budget. This past grant year the grant was for \$18,883, but then was reduced during the contract year by 2%. This year's amount reflects the 2% decrease.

Update on Influenza Vaccine and H1N1 Vaccine Plans:

This is taking up much time, and activity is expected to increase in the next few months. Please see the attached information for a summary of specifics. We will answer any questions the committee may have at the meeting.

Car Fleet Concerns:

We have recently conferred with Scott Congel and Bruce Belden at DPW regarding various issues pertinent to the Health Services Vehicle Fleet. Communication is good between the two departments, and our only wish is that more routine kinds of maintenance procedures could be done at the Municipal Center as opposed to the cars having to go to Warrensburg. However, in the big scheme these days, that is a small concern!

The issue needing discussion at the Health Services Committee is consideration of a contract agreement with Nemer Ford in order to receive rust proofing for nine vehicles, specifically the white Ford Focuses, which are all showing signs of rust.

Mr. Congel reports he has done work with Nemer and feels their price is good. Since we have never gotten rust proofing on our vehicles when they were new, (something that will be recommended and put in specs in the future) I spoke with Julie Pacyna, Warren County Purchasing Agent, who recommended developing a contract with an amount not to exceed two thousand dollars per year. This amount keeps it under the threshold for Public Works projects where bids would be necessary. We have sufficient funds in our 2009 to do this, and the contract would terminate December 31, 2009. In light of the fact that the cars need to last longer, this is prudent.

If the committee is agreeable we will need to:

Request Resolution:

To authorize a contract with Nemer Ford for rust proofing services for Health Services fleet vehicles in an amount not to exceed \$2,000 per year, for the period October 19, 2009 through December 31, 2009.

Report of Revenues and Expenditures (please see the attached information)

Report of Overtime Costs and Use of Per Diem Nurses (to be distributed at the meeting)

Tawn Driscoll, Fiscal Manager, will be present at the meeting to answer any questions.

Attachments:

Emergency Preparedness Activity Report for September 2009

Influenza and H1N1 Summary Sheet

Report of Revenues and Expenditures

Report of Overtime Costs and Use of Per Diem Nurses

WARREN COUNTY BUDGET ANALYSIS

REVENUE AND EXPENDITURES FOR 2009 AS OF 9/22/2009 5:11:59 PM

FUND(S): A, CL, D, DM, EF, GI, MS, SD, V

CODE(S): 4010, 4011, 4013, 4016, 4018, 4046, 4054, 4189, 9061, 4025

	2009 BUDGETED	2009 YTD ACTUAL	2008 Prior Year Totals
EXPENSES			
Salaries - Regular	\$3,150,622.00	\$2,116,624.47	\$3,019,322.32
Salaries - Overtime	\$172,838.00	\$130,577.04	\$209,579.17
Salaries - Part Time	\$371,256.00	\$191,195.50	\$327,600.22
Salaries - Sick Leave Incentive			\$800.00
100's PERSONAL SERVICES	\$3,694,716.00	\$2,438,397.01	\$3,557,301.71
200's EQUIPMENT	\$15,000.00	\$1,644.97	\$69,518.54
400's CONTRACTUAL	\$9,792,157.76	\$5,408,972.92	\$9,708,382.75
800's EMPLOYEE BENEFITS	\$62,422.00	\$59,874.93	\$57,581.33
TOTALS	\$13,564,295.76	\$7,908,889.83	\$13,392,784.33
REVENUES			
	2009 BUDGETED	2009 YTD ACTUAL	2008 Prior Year Totals
	\$12,278,428.00	\$5,849,423.60	\$11,961,592.19

Note: 2009 Revenues reflect an estimated accrual for July of \$375,000 for the CHHA, LTC and MCH programs. We are currently working on finalizing August. Also accrued is the August WIC voucher for \$63,986 which includes reimbursement for J. Spencers benefit cash out. An accrual of \$38,258 has also been made for Preschool reimbursement based on 05/06 final rate recons recently billed and paid.

Warren County Health Services

Salaries Comparison

2008 vs 2009

as of 9/13/09 for 19 payrolls

19

Total of All Depts	2009	2008	YTD 09v08	Percentage Change	Estimated Annual Expenses	Budget 2009	Actual 2008
Regular Salaries	\$2,116,624.47	\$2,100,079.33	\$16,545.14	0.79%	\$2,896,433.49	\$3,177,622.00	\$3,019,322.00
Overtime Salaries	\$130,577.04	\$151,289.15	-\$20,712.11	-13.69%	\$178,684.37	\$172,838.00	\$209,579.00
Part Time Salaries	\$191,195.50	\$226,389.04	-\$35,193.54	-15.55%	\$261,635.95	\$371,256.00	\$327,600.00
TOTALS for 19 Pay periods	\$2,438,397.01	\$2,477,757.52	-\$39,360.51		\$3,336,753.80	\$3,721,716.00	\$3,556,501.00
Estimated Savings						-\$384,962.20	-\$219,747.20

*Source: Detail G/L report for all Salary Category from 1/1/XX-8/16/XX

Note: Payroll reflects the annual 3% increase in salaries for 2009.

Regular salaries also reflects an additional \$16,907 in August 2009, which is related to the benefit cash out of J. Spencer who retired from WIC.

This amount will be fully recovered from the WIC 08/09 Grant.

Warren County Health Services
Influenza Update
9/22/09

Seasonal Influenza: Varying viruses circulate every year and infect up to 20% or more of the population. Generally seasonal flu circulates fall and winter. (Vaccine is here now and clinics have begun)

Novel H1N1 Influenza: New virus circulating in US since 4/09. Most of the population does not have immunity to this virus. (Vaccine anticipate by Nov 1)

Recommendations:

1. Seasonal Flu Vaccination: Encourage all residents to get vaccinated.
2. Pneumonia Vaccination: Encourage residents with underlying medical conditions to consult provider
3. H1N1 Vaccination: All residents when available (?Nov 1), starting with priority groups
4. Hand washing- Everyone
5. Respiratory etiquette- Everyone
6. Staying home when ill- everyone
7. Depending on severity of illness, recommendations may change

Plan:

1. Start Seasonal Vaccination Clinics early (Providers, Hospitals, and Local Health Departments)
2. H1N1 Vaccine distribution to Hospitals, Providers and Local Health Departments
(Currently, providers and hospitals are registering with NYS to receive vaccine)
3. Public Health will offer clinics, based on availability of vaccine to the community, first supporting priority groups.
4. Priority Groups (3 Phases)
 - a. **Phase I:** The following groups are included in the first target for H1N1 vaccination
 - i. Pregnant women
 - ii. Household contacts and caregivers of infants less than 6 months old
 - iii. Health Care Workers/ Emergency Services
 - iv. Children, adolescents, and adults **6mo-24 yrs old.**
 - v. **Adults 24-64yrs with medical conditions making them at high risk for complications from the flu.**
*If Initial H1N1 supply is not sufficient for the groups above, priority will be to pregnant women, Household contacts/caregivers of infants less than 6 mo old, Health Care Workers/EMS, Children 6 mo-4 yrs, and Children and Adolescents 5-18yrs with a medical condition that puts them at high risk.
 - b. **Phase II:** Once there is enough vaccine to cover Phase 1, the following groups are included in the 2nd target for vaccination
 - i. All adults 25-64 yrs
 - c. **Phase III:** Once there is enough vaccine to cover phase I and II, the following group/s will be included in the next target:
 - i. All adults 65 yrs and older
(Current trends show this group has not had many H1N1 cases. One thought is that some immunity exists from exposure years ago- This group however, is recommended for the seasonal flu vaccine as historically those over 65yrs have been affected and can be at high risk for complications)

General Information on the Novel H1N1 Influenza Vaccine:

- o Formulated just like seasonal vaccine but with a change in the influenza strain that is included;
- o Contain only H1N1 strain;
- o Be a licensed vaccine;
- o Be available in both the injectable form and the nasal spray;
- o Be available in limited quantities without thimerosal
- o Anticipated to be available by Nov 1st;
- o Require 1 or 2 doses (If 2 doses are required, doses will be spaced by 3-4 weeks);
- o Be provided at no cost by the Federal Government;
- o Can be given at the same time as the seasonal vaccine; and
- o Be safe and effective.

Surveillance:

1. Schools
2. Providers
3. Hospital
4. Nursing Homes

WARREN COUNTY HEALTH SERVICES

BT ACTIVITY SHEET

GY 10 - 8/10/2009 - 8/9/2010

Page 1

Topic Color Codes

Red/Chempack; Green/SNS; Blue/Mass Fatality; Black/Training; Orange/Drill; Purple/Pan Flu

Date	Type	Subject/Comments	Attendees	Topic (i.e. Drill, SNS, Fatality, Chempack, Training, Pan Flu)
General	Updates	H1N1 mailings, emails, blast fax, etc. (see H1N1 files)	Ginelle Jones, Laura Saffter et al	Pan Flu
9/1/09	Meeting	With Medical Directors - H1N1	Pat Auer, Ginelle Jones et. al	Pan Flu
9/2/09	Meeting	At Airport as a possible primary SNS Site	Pat Auer, Ginelle Jones, Barb Orton	SNS
9/3/09	Meeting	Mass Fatality Committee	Barb Orton et. al	Mass Fatality
9/8/09	Meeting	Monthly BT Coordinators	Barb Orton, Laura Saffter	
9/9/09	Drill	L-16 - Commerce Notification Drill (SNS staff)	Ginelle Jones	SNS
9/10/09	Meeting	H1N1 update by NYSDOH in Rensselaer	Barb Orton	Pan Flu
9/14/09	Meeting	Planning for GFH ACS Drill on 10/3/09	Barb Orton, Laura Saffter	Pan Flu
9/14/09	Conference Call	GY10 BT Funding	Ginelle Jones, Laura Saffter	
9/15/09	Survey	County H1N1 Workforce Survey	Ginelle Jones	Pan Flu
9/15/09	Conference Call	H1N1	Pat Auer, Ginelle Jones	Pan Flu
9/16/09	Meeting	Warrensburg School - H1N1 Updates	Barbara Orton	Pan Flu
9/16/09	Tabletop	Monthly GFH - Gang violence incident at local school	Barb Orton	
9/18/09	Education Seminar	L-5 - H1N1 Planning, SNS Response, etc.	Laura Saffter	SNS
9/23/09	Conf Call/Webinar	Clinic Ops	Barbara Orton, Angela Meade	SNS
9/29/09	Meeting	Grand Rounds at GFH - H1N1	Ginelle Jones, Pat Belden, Helen Stern, Barbara Orton	Pan Flu

RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: Health Services

DATE: September 25, 2009

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: To authorize an agreement with NYSDOH to allow receipt of grant funds for the WIC Program in the amount of \$549,953
- (c) Name of Contractor: NYSDOH Bureau of Supplemental Foods Division of Nutrition
- (d) Address of Contractor: Riverview Center, 180 Broadway, Albany, NY 12204-2719
- (e) Contractor's Contact Person and Telephone Number: Tim Mooney, Resource Planning and Operations, 402-7099
- (f) Has or will the Contract be provided, if so, please attach: to be submitted and prepared electronically
- (g) Commencement Date of Contract: 10/1/09
- (h) Termination Date of Contract: 9/30/10
- (i) Payment Provisions:
 - i) lump sum amount
 - ii) hourly rate amount
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. quarterly, voucher submission with expense justification)
- (j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: OR Capital Project OR Capital Reserve Project Number, and Title, and Amount: Expenses A4013 Various codes; Revenues A4013.4403

Warren County Board of Supervisors

RESOLUTION NO. 566 OF 2008

Resolution introduced by Supervisors Sokol, Sheehan, Haskell, Thomas, Tessier, Champagne and O'Connor

**AUTHORIZING AGREEMENT CONTINUING CONTRACTUAL RELATIONSHIP WITH
NEW YORK STATE DEPARTMENT OF HEALTH FOR SPECIAL SUPPLEMENTAL
FOOD PROGRAM FOR THE WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM
- HEALTH SERVICES DEPARTMENT**

RESOLVED, that Warren County continue the contractual relationship (the previous contract being authorized by Resolution No. 588 of 2007) with the New York State Department of Health, Resource Planning and Operations Unit, Riverview Center, 150 Broadway, Albany, New York 12204-2719, for participation in the Special Supplemental Food Program for the WIC Program within Warren County, for an amount not to exceed Four Hundred Thirty-Five Thousand Eight Hundred Eight Dollars (\$435,808), for a term commencing October 1, 2008 and terminating September 30, 2009, and with certain modifications to the original agreement more specifically set forth in the agreement and appendices, and the Chairman of the Board of Supervisors be, and hereby is, authorized to execute said agreement in the form approved by the County Attorney, and be it further

RESOLVED, that the Chairman of the Board of Supervisors be, and hereby is, authorized to execute any and all documents necessary to accept any Cost of Living Adjustment (COLA) payments that the County may receive in a form approved by the County Attorney.



STATE OF NEW YORK DEPARTMENT OF HEALTH

Riverview Center 150 Broadway Albany, New York 12204-2719

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 15, 2009

Patricia Auer
Director of Public Health
Warren County Health Services
Gurney Lane- WIC Main Office
1340 State Route 9
Lake George, NY 12845

Dear Ms. Auer:

The Department of Health (DOH) has completed its review of the Request for Applications for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), WIC Vendor Management Agency (VMA) and Commodity Supplemental Food Program (CSFP).

I am pleased to inform you that your agency has been recommended to receive an award to provide **WIC** services. The grant award for the first year of the five-year contract cycle is \$549,953. Please note that this award is subject to approval by the New York State Office of the State Comptroller.

Your agency's WIC contract under this procurement will begin on October 1, 2009 and will be renewable annually for four additional one year periods. Shortly, you will receive more information on your grant award including a WIC local agency grant contract for your signature. Please be advised your agency will receive reimbursement for WIC-related expenditures incurred after October 1 once your WIC contract is executed.

If your agency is a current WIC provider, please continue program operations during this interim period. If your agency is a new WIC sponsor, one of our regional office staff will contact you regarding program implementation.

Congratulations on submitting a successful application. I look forward to working with your agency over the next five years. If you have any questions about this process, please contact your DOH Regional Office at (518) 408-5278.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy Mooney". The signature is fluid and cursive, with the first name "Timothy" written in a larger, more prominent script than the last name "Mooney".

Timothy Mooney, Director
Bureau of Supplemental Food Programs

cc: Michelle Locke, Regional Office Representative
Frederick Monroe, Chairman, County Board of Supervisor
Kathy Harris, WIC Coordinator

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: September 25, 2009

- (a) Purpose of Contract Change: to renew contract with NYSDOH Children With Special Health Care Needs in the amount of \$18,505
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 586/2007, see attached copy of resolution
- (c) Name of Contractor: NYSDOH Division of Family Health Fiscal Unit
- (d) Address of Contractor: ESP Corning Tower, Room 878, Albany, NY 12237-0657
- (e) Contractor's Contact Person and Telephone Number: Kristin Kuentzel, 474-4569
- (f) Commencement Date of Amendment: 10/1/09
- (g) Termination Date of Extension: 9/30/10
- (h) Payment Provisions:
 - i) lump sum amount
 - ii) hourly rate amount
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. quarterly with voucher submission upon receipt of approved contract and work plan)
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: A4018.0020.4451

Warren County Board of Supervisors

RESOLUTION NO. 271 OF 2008

Resolution introduced by Supervisors Sokol, Sheehan, Haskell, Thomas, Tessier, Champagne and O'Connor

**AUTHORIZING AGREEMENT TO CONTINUE AGREEMENT
WITH NEW YORK STATE DEPARTMENT OF HEALTH FOR FUNDING OF
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM
- HEALTH SERVICES DEPARTMENT**

RESOLVED, that Warren County continue the agreement (the previous agreement being authorized by Resolution No. 586 of 2007) with New York State Department of Health, Division of Family Health, Fiscal Unit, Corning Tower, Room 878, The Governor Nelson A. Rockefeller Empire State Plaza, Albany, New York 12237, for funding for the Children with Special Health Care Needs (CSHCN) Program, for a term commencing October 1, ²⁰⁰⁹~~2008~~ and terminating September 30, ²⁰¹⁰~~2009~~, for an amount not to exceed Eighteen Thousand ^{Five}~~Eight~~ Hundred ^{Five}~~Eighty-Three~~ Dollars (⁵⁰⁵~~\$18,883~~), and the Chairman of the Board of Supervisors be, and hereby is, authorized to execute an agreement in the form approved by the County Attorney.



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 14, 2009

Patricia Auer
Director of Public Health & Patient Services
Warren County on behalf of Warren County Health Services
1340 State Route 9
Lake George, New York 12845

Dear Ms. Auer:

This is to inform you of the Department's intention to provide funding for the Children with Special Health Care Needs program for the period October 1, 2009-September 30, 2010. Contracts are renewable annually contingent upon funding availability and contractor performance. Your new contract number is C-024650, please use this number on all contract related documents. Your funding amount for this period is \$18,505. Please submit a budget and workplan for the period October 1, 2009-September 30, 2010 contract cycle.

The contract amount includes optional additional funding in the amount of \$343. If accepted, these funds must be used to support families of children with special health care needs (CSHCN) and youth and young adults with special health care needs (YAYASHCN) in program involvement, empowerment or leadership activities. These nonpersonal service funds can be utilized for supports which include but are not limited to: projects or meetings which are for consumers (families of CSHCN or YAYASHCN); consumer stipends for involvement as participants or presenters in meetings or trainings; or consumer travel which facilitates participation in leadership, empowerment or program development activities. These funds are to be utilized to support families of CSHCN and YAYASHCN across the spectrum of birth to 21 years. These funds can not be used to support consumer involvement in Local Early Intervention Coordinating Council meetings or activities that are solely focused on the birth to age three population. These funds can not be utilized for staff development.

Please complete the enclosed budget and workplan forms and return to my attention to the following address by **October 14, 2009**:

NYS Department of Health
Division of Family Health, Fiscal Unit
ESP Corning Tower - Room 878
Albany, NY 12237-0657

Please contact me for budget related questions at (518) 474-4569 or by e-mail at kxk02@health.state.ny.us. Budget and workplan forms may also be requested electronically by contacting me. For programmatic questions or for guidance, please contact your Regional Office contact or Sue Slade at (518) 402-5706 or by e-mail at sjs11@health.state.ny.us. Upon review and approval of the budget and workplan, a contract will be sent under separate cover for signature and notarization. Thank you.

Sincerely,

Kristin Kuentzel
Health Program Administrator
Fiscal Unit, Division of Family Health

Enclosures

cc: Sue Slade

PART 1

Children with Special Health Care Needs Program

Instructions For Completing Operating Budget and Funding Request

(Tables A, A-1 and A-2)

IN COMPLETING TABLES A-1 THROUGH A-4, LIST THE PERSONAL SERVICES AND NONPERSONAL SERVICES THAT SUPPORT THIS INITIATIVE, EVEN IF NO FUNDING IS BEING REQUESTED FROM NYS.

TABLE A (Operating Budget and Funding Request Summary Sheet)

This table will summarize the sub and grand totals on Tables A-1 and A-2.

TABLE A-1 (Personal Services):

List ALL personnel working on this grant, even if no funding is being requested from NYS. Failure to list ALL personnel on Table A-1 may result in the disapproval of future requests for budget revisions.

Column No.:

- (1) Personal Services: List ALL personnel working on the grant, even if no funding is being requested from NYS.
- (2) Annual Salary - enter the amount of funding needed to support this position for 12 months on a full-time basis, regardless of funding source.
- (3) Number of Months Funded - enter the number of months the position will be funded by this grant. Note: the number of months may be less than the contract period, but cannot exceed the number of months in the contract period.
- (4) Percent (%) FTE - enter the % of time the incumbent will work on the grant on a full-time basis. One (.1) FTE is based on the number of hours worked in one week (e.g. 40 hour workweek). To determine a % FTE, divide the hours per week spent on the project, by the number of hours in the workweek. For example: given a 40 hour workweek, an individual working 10 hours per week on the project spends .25 percent of his/her time on the project (i.e. $10/40 = .25$) Please show in decimal form.
- (5) Total Expenses - To calculate, multiply the full-time annualized salary by the % FTE. Multiply the result by the number of months funded divided by 12 (i.e. $\text{salary} \times \% \text{ FTE} \times \# \text{ of months funded} / 12$).

- (6) Amount requested from NYS - enter the amount of total expenses (see Column 6) requested to be reimbursed by NYS.
- (7) Other Sources - include amounts expected to be received from all other sources, including Medicaid Administrative Funding (for services other than transportation as provided for in LCM-23), local appropriation, in-kind, 3rd party billing, revenue earned from items funded by this grant, etc. A separate amount should be indicated for each source of funding specified in column 8.
- (8) Specify Other Sources - specify the source of funds for each amt. shown in Column 7.
- See Subtotal Salaries line - enter the subtotal of the salaries in Columns 5, 6 and 7.
- See Fringe Benefits - show the percentage of Fringe Benefits derived on Fringe Benefit Rate Form 2. Multiply this rate by the sub-total of the salaries in Column 5 and enter the result on the Fringe Benefits line in Column 5. In Column 7 on this budget line, sum the dollar amounts in Columns 5 and 6.
- See Subtotal PS line - sum the "Sub-Total Salaries" amounts and "Fringe Benefits" amounts shown in Columns 5, 6 and 7.

TABLE A-2 (Nonpersonal Services)

List ALL nonpersonal expenses related to this grant, even if no funding is being requested from NYS. Failure to list ALL nonpersonal expenses on Table A-2 may result in the disapproval of future requests for budget revisions.

Column No.:

- (1) Nonpersonal Services - List **ALL** expenses related to this grant, even if no money is being reimbursed from NYS.
- (2) Total Expenses - The total expenses for all items should be indicated. This column must equal the sum total of the figures in columns 3 and 4.
- (3) Amount Requested from New York State - Direct funding requests to New York State will be indicated by all of the amounts in this column.
- (4) Other Sources of Funds - include amounts expected to be received from all other sources including Medicaid Administrative Funding (for services other than transportation as provided for in LCM-23), local appropriation, in-kind, 3rd party billing, revenue earned from items funded by this grant, etc. A separate dollar amount should be indicated for each source of funding specified in column 5.
- (5) Specify Other Sources - Specify the source of funds for each amt. shown in Column 4.

NOTE: THE OPERATING BUDGET AND FUNDING REQUEST MUST BE ACCOMPANIED BY THE BUDGET NARRATIVE/JUSTIFICATION FORMS.

**APPENDIX B
 TABLE A
 BUDGET SUMMARY**

**Children with Special Health Care Needs Program
 OPERATING BUDGET AND FUNDING REQUEST**

Contract Period: October 1, 2009 - September 30, 2010

	=	+	+	+	
	Total Expenses	Amount Requested from NYS	Other Source	Specify Other Sources	
Subtotal Personal Service (Total Line Only from Table A-1):	\$0	\$0	\$0	See Table A-1	
Subtotal Nonpersonal Service (Total Line Only from Table A-2):	\$0	\$0	\$0	See Table A-2	
GRAND TOTAL	\$0	\$0	\$0		
					CFDA INFORMATION
					Federal Funds
					93.994: Maternal and Child Health
					Services Block Grant (100%)

**APPENDIX B
TABLE A-1
CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
OPERATING BUDGET AND FUNDING REQUEST
OCTOBER 1, 2009- SEPTEMBER 30, 2010**

PERSONAL SERVICES (PS)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
List the title of ALL personnel working on the grant, even if no funding is being requested from NYS:	Annual Salary	# of Months Funded	% FTE Annual (please show in decimal form (e.g..25)	Total Expenses	Amount Requested From NYS	Funds From Other Sources	Specify Other Sources of Funds
Sub-Total Salaries							
Fringe Benefit Rate							
Sub-Total PS							

APPENDIX B
TABLE A-2
CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
OPERATING BUDGET AND FUNDING REQUEST
OCTOBER 1, 2009 - SEPTEMBER 30, 2010

NONPERSONAL SERVICES (OTPS)		[(2) - (3)]		
		(2)	(3)	(4)
(1)	(2)	(3)	(4)	(5)
List ALL expenses related to this initiative even if no funding is being requested from NYS:	Total Expenses	Amount Requested From NYS	Other Sources of Funds	Specify Other Sources of Funds
Printing and Copying Postage Supplies (including software) Telephone Travel: In-State Out-of-State Training Equipment Consumer Involvement Purchased Services: Subcontractors Consultants Other (please itemize):				
Total Nonpersonal Services				
Total Personal Services				
GRAND TOTAL (total expenses from Tables A-1 and A-2)				

PART 2

Children with Special Health Care Needs Program

BUDGET NARRATIVE/JUSTIFICATION FORMS

Contractor Name: Warren County o/b/o Warren County Health Services

Contract No.: C-024650

Contract Period: October 1, 2009 through September 30, 2010

Contact Person: _____

Telephone Number: (_____) _____

Fax Number: (_____) _____

Using the attached format, provide a justification for the expenses included in each category listed in the operating budget and funding request, Tables A through A-2. The justification must include various items of expense (and estimated costs) that comprise the amount requested for each budget category, and an explanation of how the expenses listed relate to the goals and objectives of the program.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM

**BUDGET NARRATIVE/JUSTIFICATION
INSTRUCTIONS**

Forms 1, 2, 3, 3a, 3b and Workplan:

Forms 1 and 2 Personal Services:

Form 1 must include a description for each position contained in Table A-1. The percentage of time spent on various duties, where appropriate, must be included. Contracted, consultant or per-diem staff are not to be included in the description/justification. These expenses should be shown as consultant or contractual services under the "Nonpersonal Services" section of Form 3.

Forms 3, 3a and 3b Nonpersonal Services:

Supplies and Materials (including software):

Definition: **Any item with a per unit cost of \$500 or less.** Software cost should be broken-out separately under supplies, regardless of cost. Provide a delineation of the items of expense and estimated cost of each along with a justification of their need.

Note: Some supplies may be consolidated under the heading of Office Supplies, Medical Supplies, etc.

Equipment:

Definition: **Any item with a per unit cost of \$500 or more.** Provide a delineation of each piece of equipment and estimated cost along with a justification of need.

Explanations should be more detailed if the equipment is unique or if special features are included that justify a higher cost. Note: Software costs should be budgeted under Supplies and Materials and broken-out separately. Also, each item charged to the Equipment line must be reported on the Equipment Inventory Report at the end of the year.

Travel:

Complete Form 3a as appropriate and enter amounts on table A-2.

Consumer Involvement:

Form 3b must list what the \$350 funding will be used for, how much will be spent on each activity along with a description/justification of their need. This funding will be listed on Table A-2 under "Nonpersonal Services" as "Consumer Involvement".

Other Expenses:

List any item of expense not included elsewhere in the budget. Items might include: insurance, space occupancy, advertising, etc. Include a justification and allocation methodology for EACH item listed.

Contractor: Warren County o/b/o Warren County Health Services
Contract No.: C-024650

**CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
BUDGET NARRATIVE/JUSTIFICATION
FORM 1**

October 1, 2009 through September 30, 2010

PERSONAL SERVICES (PS):

Title(s)	Incumbent Name(s)	Description/Justification (use additional sheets if necessary)

**CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
 FRINGE BENEFIT RATE
 FORM 2**

October 1, 2009 through September 30, 2010

PART A

Does your organization have a federally approved fringe benefit rate?

Yes: _____ If yes, you do not have to complete Part B.

Federally Approved Rate: _____ Period of Applicability: _____ Attach copy of Federal Approval - all pages.

No: _____ If no, proceed to Part B.

PART B

Specify the components and percentages comprising the fringe benefit rate.

Note: If positions have different fringe benefit rates, please use an average for all positions.

Component	Rate
F.I.C.A (6.2%) & Medicare Tax (1.45%)	7.65%
Health Insurance	
Unemployment Insurance	
Disability Insurance	
Life Insurance	
Worker's Compensation	
Pension/Retirement	
Other: (delineate)	
*Total Fringe Rate	

*This rate must be equal to the percentage shown in the budget, Appendix B, Table A-1.

Example: Insurance - The total policy for the agency is \$5,000. This contract constitutes 15% of the total agency budget, as such, the amount requested is \$750.

\$150,000 contract amount

\$1,000,000 agency budget = 15%

15% x \$5,000 = \$750

Subcontracts/Consultant Services:

Provide a listing of all subcontracts, including consultant contracts which will support contract deliverables along with a description of the services to be provided. This should include all contracts that support the program even if funded by other sources. Include an estimate of the number of hours to be worked and the rate per hour, if applicable, for subcontracts supported in full or in part with requested funds.

If the subcontractor/consultant has not yet been selected, please indicate "**Not Selected**" under the Subcontractor/Consultant line and provide all other pertinent information.

Note: A copy of the subcontractor/consultant agreement must be submitted before these expenses can be approved for reimbursement.

Workplan

Complete workplan by describing your proposed activities in the workplan areas. Describe the strategy(s) you will use to accomplish the workplan activities and how you plan to measure your progress in the workplan areas.

Contractor: Warren County o/b/o Warren County Health Services

Contract No.: C-024650

**CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
BUDGET NARRATIVE/JUSTIFICATION
FORM 3**

October 1, 2009 through September 30, 2010

NONPERSONAL SERVICES (OTPS)

Item(s)	Cost	Description/Justification (use additional sheets if necessary)

**CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
BUDGET NARRATIVE/JUSTIFICATION**

FORM 3a
October 1, 2009 through September 30, 2010

**PROVIDE A DELINEATION OF THE FUNDING REQUESTED IN EACH OF THE FOLLOWING SUB-CATEGORIES IF APPLICABLE,
ATTACHING ADDITIONAL SHEETS AS NECESSARY.**

Staff and Volunteer Travel Include number of staff, titles of staff and volunteer estimated travel costs (including transportation, lodging and meals for the contract period), and purpose of travel. \$ _____

Out-of-State and Conference Travel Provide an estimate of the amount you anticipate spending on out-of-state and conference travel along with a delineation of the travel (as noted in the examples below) and a justification of how the travel relates to program objectives. All out-of-state travel must have prior approval. \$ _____

Examples:

In-State: Program Coordinator and Data Coordinator to attend 2 related in-State conferences; 2 staff X 2 conferences each X \$300 per conference (including transportation, lodging and meals) = \$1,200.

Out-of-State: Program Coordinator and Data Coordinator to attend conference (including transportation, lodging and meals) at a cost of \$900 per person = \$1,800. Note: If the location of the conference is known, it should be indicated. If it is not known, it must be submitted with the voucher on which reimbursement is claimed.

TOTAL FUNDING REQUESTED FOR TRAVEL: * \$ _____

* Note: The amount shown here must equal the total cost of travel found on Table A-2.

Contractor: Warren County o/b/o Warren County Health Services
Contract No.: C-024650

**CONSUMER INVOLVEMENT FUNDS
CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
BUDGET NARRATIVE/JUSTIFICATION**

FORM 3b

October 1, 2009 through September 30, 2010

Item(s)	Cost	Description/Justification (use additional sheets if necessary)

APPENDIX D
 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
 OCTOBER 1, 2009 – SEPTEMBER 30, 2010

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
<p>Information & Referral: Families of CSHCN will receive information and referrals to insurance, health services, and community resources to address their identified needs.</p> <p>Data: All data will be reported in a timely manner in accordance with Appendix C, Section II of the Payment and Reporting Contract Requirements.</p>	<p>1) 100% of families of CSHCN who are uninsured or underinsured will be provided with information regarding health and dental insurance and gap-filling programs, referred to available public insurance and gap-filling programs, and enrolled as appropriate.</p> <p>2) 100% of families of CSHCN with health-related needs will be assisted in accessing appropriate community resources.</p> <p>1) Data will be reported quarterly throughout the year and submitted to the Division of Family Health - Fiscal Unit.</p>			<p>1) All reported services rendered each quarter will be entered into the CSHCN data application. Ongoing involvement, as in referrals made or in pending status, and/or receipt of needed services will be reflected in the data.</p> <p>2) Same as #1 above.</p> <p>1) Data will be received in the Division of Family Health Fiscal Unit no later than 45 days after the end of the quarter (i.e. 2/14/10 1st quarter, 5/15/10 2nd quarter, 8/14/10 3rd quarter; and 11/14/10 4th quarter).</p>	

APPENDIX D
 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
 OCTOBER 1, 2009 – SEPTEMBER 30, 2010

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
<p>Quality Improvement: Gaps and barriers to access health care and related services and resources for families are identified.</p>	<p>1) Grantee will identify barriers to health care and related services and resources via: contacts with families, (particularly culturally diverse families) and providers; interactions with resources in the community; and involvement in community coalitions, professional organizations and other groups.</p> <p>2) Grantee will suggest strategy(ies) for addressing identified barriers, including those for culturally diverse families.</p> <p>3) Grantee will initiate proposed strategy(ies) to the extent possible, review and report progress to overcome the barriers, and permanently implement to the degree possible the strategy(ies) that are effective.</p>			<p>1) The grantee will report for each quarter the barriers encountered and the progress and successes in resolving them.</p> <p>2) Same as #1 above.</p> <p>3) Same as #1 above.</p>	

APPENDIX D
 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
 OCTOBER 1, 2009 – SEPTEMBER 30, 2010

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
<p>Outreach: Each grantee will perform outreach activities at a minimum of once a quarter.</p>	<p>1) At least quarterly, information about the CSHCN Program is disseminated to the community targeting families (including culturally diverse populations) of CSHCN and providers. Methods for dissemination may include provider detailing, meetings, email, and distribution through the Post Office.</p> <p>2) The CSHCN Program will have a culturally and linguistically appropriate current publication to use for outreach.</p> <p>3) Information about health insurance (including Medicaid, Child Health Plus, and Family Health Plus) and other resources targeting families of CSHCN are disseminated to the community. Methods may include website development, resource lists, and local phone information lines.</p>			<p>1) Outreach efforts are documented in the narrative quarterly report, including target audience, location and medium used. All relevant newly published literature is attached to the quarterly report.</p> <p>2) A publication describing the CSHCN Program is utilized in outreach efforts.</p> <p>3) Same as #1 above.</p>	

APPENDIX D
 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
 OCTOBER 1, 2009 – SEPTEMBER 30, 2010

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
<p>Other (Optional): Please specify if offering any other services. These areas are suggested:</p> <p>Medical Homes: Foster awareness of the medical home concept as defined by the American Academy of Pediatrics (AAP).</p> <p>Staff Development: Staff development opportunities are provided to CSHCN staff to ensure they are an effective resource for families of CSHCN.</p>	<p>If you choose one or more of the optional activity areas, the corresponding objectives apply:</p> <p>1) At least once a year, information is distributed to families and providers about the medical home concept.</p> <p>2) At least once a year, presentations are offered to families and providers about the medical home concept.</p> <p>1) At least once a year, staff is offered opportunities to learn about available resources, medical diagnoses, cultural competency, and program policy and procedures.</p>			<p>1) Narrative reports will describe the target population, the information distributed, and the quantity of information distributed.</p> <p>2) Narrative reports will indicate the number of presentations given and the number of participants.</p> <p>1) Narrative reports will describe staff training and development and note staff attendance.</p>	

APPENDIX D
 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
 OCTOBER 1, 2009 – SEPTEMBER 30, 2010

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
<p>Other (Optional): Please specify if offering any other services. These areas are suggested:</p> <p>Lending Library: Print and audio/visual resources will be made available to families and other community members.</p>	<p>1) A lending library of culturally and linguistically appropriate print and audio/visual resources is developed, maintained and made available for families of CSHCN and other community members.</p>			<p>1) Quarterly narrative reports detail the number of individuals served by the lending library.</p>	
<p>Transition: Youth and families are prepared for transition to the adult world of health, learning, living, and earning.</p>	<p>1) Effective initially at age 14, paper and electronic culturally appropriate resources are offered to 100% of youth and families regarding transition to adult health care providers, sources of health insurance, and vocational services.</p>			<p>1) Narrative reports describe resources and activities offered for youth and families related to transition.</p>	

APPENDIX D
 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
 OCTOBER 1, 2009 – SEPTEMBER 30, 2010

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
<p>If the additional OTPS funds are accepted, these funds must be utilized for consumer involvement.</p> <p>Consumer involvement: Increase consumer (families of CSHCN and youth and young adults with special health care needs) involvement in the local CSHCN Program.</p>	<p>1) At least once during the year, consumers, including those of culturally diverse populations, are involved in meetings, trainings or other types of activities which improve their own or others (i.e. providers) knowledge, attitudes or skills or enhance program development.</p> <p>2) Funding is provided for consumer stipends, travel, and attendant and/or childcare expenses while participating in these activities.</p>			<p>1) Narrative reports will document consumer involvement in meetings, trainings or other activities.</p> <p>Quarterly vouchers will document reimbursement for consumer stipends, travel, and attendant and/or child care.</p>	

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: September 25, 2009

- (a) Purpose of Contract Change: to rescind Reso 548/2009 that authorized submission of application to NYSDOH Bureau of Community Chronic Disease Prevention to develop a local action plan to implement a policy and environmental changes
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 548/2009
- (c) Name of Contractor: NYSDOH Bureau of Community Chronic Disease Prevention
- (d) Address of Contractor: 150 Broadway, Riverview Center, Room 350, Albany, NY 12204
- (e) Contractor's Contact Person and Telephone Number: Kyle Restina, 408-5152
- (f) Commencement Date of Amendment: 8/1/09
- (g) Termination Date of Extension: 3/31/10
- (h) Payment Provisions: n/a
 - i) lump sum amount
 - ii) hourly rate amount
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount:

Warren County Board of Supervisors

RESOLUTION NO. 548 OF 2009

Resolution introduced by Supervisors Sokol, Sheehan, Thomas, Champagne, O'Connor, Stralner and Pitkin

AUTHORIZING SUBMISSION OF APPLICATION TO NEW YORK STATE DEPARTMENT OF HEALTH BUREAU OF COMMUNITY CHRONIC DISEASE PREVENTION TO DEVELOP A LOCAL ACTION PLAN TO IMPLEMENT A POLICY AND ENVIRONMENTAL CHANGES - HEALTH SERVICES DEPARTMENT

WHEREAS, the Director of Public Health/Patient Services has requested to submit a grant application to the New York State Department of Health Bureau of Community Chronic Disease Prevention for a non-competitive award in an amount not to exceed Thirty-Four Thousand Dollars (\$34,000) to develop a local action plan to implement a policy and environmental changes to address the physical activity and nutrition objectives in the Department of Health's Prevention agenda, now, therefore, be it

RESOLVED, that the Chairman of the Board of Supervisors is hereby authorized to execute and submit an application to the New York State Department of Health Bureau of Community Chronic Disease Prevention, for receipt of grant funds for a non-competitive award in an amount not to exceed Thirty-Four Thousand Dollars (\$34,000) to develop a local action plan to implement a policy and environmental changes to address the physical activity and nutrition objectives in the Department of Health's Prevention agenda, and be it further

RESOLVED, that upon receipt of grant funds, the Chairman of the Board of Supervisors is hereby authorized to execute any and all grant documents in relation to the aforementioned program in a form approved by the County Attorney, and be it further

RESOLVED, that the Chairman of the Board of Supervisors be, and hereby is, authorized to execute any and all documents necessary to accept any Cost of Living Adjustment (COLA) payments that the County may receive relating to the above-described grant, in a form approved by the County Attorney.

**Warren County Health Services
Health Services Committee Meeting
July 24, 2009
Additional Agenda Item**

Request Resolution:

To apply to the New York State Department of Health Bureau of Community Chronic Disease Prevention for a non-competitive grant for the period August 1, 2009 – March 31, 2010 in the amount of \$34,000. The purpose of the grant is to develop a local action plan to implement policy and environmental changes to address the physical activity and nutrition objectives in the Department of Health's Prevention Agenda.

Rationale:

This grant is being offered to all counties non-competitively. Since we were just made aware of it yesterday, we do not know totally what the scope of work plan responsibilities will be. Should we determine we would be unable to accomplish them, we will not apply and will let you know. The application does not need to be submitted until August 28, 2009. We never turn down funds until we have reason.

Rescind Resolution

RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: Health Services

DATE: September 25, 2009

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: To authorize contract agreement with Nemer Ford for rust proofing for Health Services fleet vehicles in an amount not to exceed \$2000/year
- (c) Name of Contractor: Nemer Ford
- (d) Address of Contractor: 323 Quaker Road, Queensbury, NY 12804
- (e) Contractor's Contact Person and Telephone Number: Steve Myhrberg, 798-8834
- (f) Has or will the Contract be provided, if so, please attach: No
- (g) Commencement Date of Contract: October 19, 2009
- (h) Termination Date of Contract: 12/31/09
- (i) Payment Provisions:
 - i) lump sum amount
 - ii) hourly rate amount
 - iii) total amount not to exceed \$2000 per vehicle amount
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: OR Capital Project OR Capital Reserve Project
Number, and Title, and Amount: A4010.441 Health Services Auto Supplies and Repair

RESOLUTION REQUEST FORM NO. 7

Request to Amend County Budget*

***If this is the result of a grant award, also complete and submit
Form No. 5 or 6**

DEPARTMENT NAME: Warren County Health Services-Bioterrorism Program

DATE: September 25, 2009

(a) **Purpose of Amendment:** To amend the 2009 budget to reclass the revenue for the Children with Special Health Care needs to the correct department. Previously recorded as Early Intervention revenue but should be Family Health.

(b) **Appropriation Code (with title), Object Code (with title) and Amount:**

Revenue Code (with title), and Amount: **Family Health-Children with Special Healthcare Needs (CSHCN) Revenue A.4018.0020.4452 \$18,505.00. (credit this account)**

Early Intervention- EI Revenue -A.4054.0060.4451 (\$18,505.00) (debit this account)