State of Nevada
Department of Health and Human Services
Division of Public & Behavioral Health
(hereinafter referred to as the Department)

Agency Ref. #:	SG 25024-1
Budget Account:	3213
Category:	22
GL:	8516
Job Number:	9326821C

SUBAWARD AMENDMENT #1

Program Name: Nevada State Immunization Program Office of Bureau of Child, Family & Community Wellness Shannon Bennett, sbennett@health.nv.gov	**Subrecipient Name:** Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite 210 Carson City, NV 89706-2009	**Address:** 1001 E. 9th St. Reno, NV 89512-2845
Subaward Period: 10/01/2020-06/30/2022	**Amendment Effective Date:** 10/01/2020

This amendment reflects a change to:

☐ Scope of Work ☒ Term ☒ Budget

Reason for Amendment: The purpose of this amendment is to plan and implement COVID-19 vaccination services with strike teams and mass vaccination events.

Required Changes: This language should correlate to the checkboxes above.

Current Language: Subgrant Period: 10/01/2020-06/30/2021. Total reimbursement through this subaward will not exceed $74,564. See Section B, C and D of the original subaward.

Amended Language: Subgrant Period: 10/01/2020-06/30/2022. Total reimbursement through this subaward will not exceed $163,593. See attached Section B, C and D **revised on 02/04/2021**

Approved Budget Categories	Current Budget	Amended Adjustments	Revised Budget
1. Personnel	$49,967.00	$19,341.00	$69,308.00
2. Travel	$0.00	$0.00	$0.00
3. Operating	$574.00	$0.00	$574.00
4. Equipment	$0.00	$0.00	$0.00
5. Contractual/Consultant	$15,445.00	$59,446.00	$74,891.00
6. Training	$0.00	$0.00	$0.00
7. Other	$0.00	$0.00	$0.00
TOTAL DIRECT COSTS	$65,986.00	$78,787.00	$144,773.00
8. Indirect Costs	$8,578.00	$10,242.00	$18,820.00
TOTAL APPROVED BUDGET	$74,564.00	$89,029.00	$163,593.00

Incorporated Documents:
Section C: Budget and Financial Reporting Requirements **revised on 02/04/2021** (if applicable)
Section D: Request for Reimbursement **revised on 02/04/2021** (if applicable)
Exhibit A: Original Notice of Subaward and all previous amendments

By signing this Amendment, the Authorized Subrecipient Official or their designee, Bureau Chief and DPBH Administrator acknowledge the above as the new standard of practice for the above referenced subaward. Further, the undersigned understand this amendment does not alter, in any substantial way, the non-referenced contents of the original subaward and all of its attachments.

Name	Signature	Date
Kevin Dick District Health Officer		3/4/2021
Candice McDaniel, MS Bureau Chief, CFCW	Candice McDaniel	03/05/2021
For Lisa Sherych Interim Administrator, DPBH		3/5/21

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBAWARD
Exhibit A:
SECTION C

Budget and Financial Reporting Requirements

Identify the source of funding on all printed documents purchased or produced within the scope of this subaward, using a statement similar to: "This publication (journal, article, etc.) was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 6 NH23IP922609-02-02 from The Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor The CDC."

Any activities performed under this subaward shall acknowledge the funding was provided through the Division by Grant Number 6 NH23IP922609-02-02 from The Centers for Disease Control and Prevention (CDC).

Funding Sources:	**% Funds:**
Nevada Immunization & Vaccine for Children Federal Grant (CDC) COVID-19 Funds	100%

Applicant Name: Washoe County Health District

BUDGET NARRATIVE

Total Personnel Costs including fringe **Total:** $ **49,967**

List staff, positions, percent of time to be spent on the project, rate of pay, fringe rate, and total cost to this grant.

	Annual Salary	Fringe Rate	% of Time	Months	Percent of Months worked Annual	Amount Requested
I/H RN	$64,812.80	1.750%	53.000%	9	75.00%	**$26,214**
I/H CHA	$49,504.00	1.750%	7.000%	9	75.00%	$2,644
I/H OAII	$41,600.00	1.750%	23.000%	9	75.00%	$7,302
Overtime for WCHD staff at all levels	$0.00	0.000%	0.000%	9	75.00%	**$13,807**

Total Fringe Cost	**$622**	**Total Salary Cost:**	**$49,345**
Total Budgeted FTE	0.83000		

Travel **Total:** **$0**

Identify staff who will travel, the purpose, frequency and projected costs. Utilize GSA rates for per diem and lodging (go to www.gsa.gov) and State rates for mileage (575.0 cents) as a guide unless the organization's policies specify lower rates for these expenses. Out-of-state travel or non-standard fares require special justification.

Out-of-State Travel **$0**

	Cost	# of Trips	# of days	# of Staff

Justification:
NO OUT OF STATE TRAVEL

In-State Travel **$0**

Origin & Destination	Cost	# of Trips	# of days	# of Staff	
Mileage: (rate per mile x # of miles per r/trip) x # of trips x # of staff	$0.000	0		0	$0.00

Justification: No Travel costs

Operating **Total:** **$574**

List tangible and expendable personal property, such as office supplies, program supplies, etc. Unit cost for general items are not required. Listing of typical or anticipated program supplies should be included. If providing meals, snacks, or basic nutrition, include these costs here.

Printing	Client forms and education	573.60

Justification: Operating Costs

Equipment **Total:** **$0**

List Equipment purchase or lease costing $5,000 or more and justify these expenditures. Also list any computers or computer-related equipment to be purchased regardless of cost. All other equipment costing less than $5,000 should be listed under Supplies.

Describe equipment	$0.00

Contractual **$15,445**

Identify project workers who are not regular employees of the organization. Include costs of labor, travel, per diem, or other costs. Collaborative projects with multiple partners should expand this category to break out personnel, travel, equipment, etc., for each site. Sub-awards or mini-grants that are a component of a larger project or program may be included here but require special justification as to the merits of the applicant serving as a "pass-through" entity, and its capacity to do so.

Name of Contractor or Subrecipient: Temporary staffing Services **Total** **$15,445**

Period of Performance: October 01, 2020 - June 30, 2021

Scope of Work: Staff to complete required data entry into EHR system & WebIZ

Budget

Personnel	$5,445.00
Travel	$0.00
Total Budget	$5,445.00

Method of Accountability:

Technology	EHR subscription fees/access for multiple staff	$ 10,000.00

Training **Total:** **$0**

List all cost associated with Training, including justification of expenditures.

Describe training	$0.00

Other	Total:	$0

Identify and justify these expenditures, which can include virtually any relevant expenditure associated with the project, such as audit costs, car insurance, client transportation, etc. Stipends or scholarships that are a component of a larger project or program may be included here but require special justification.

Justification:

TOTAL DIRECT CHARGES	$	65,986

Indirect Charges	Indirect Rate:	13.000%	$8,578

Indirect Methodology: 13% indirect

TOTAL BUDGET	Total:	$74,564

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBAWARD

Applicant Name: Washoe County Health District

Form 2

PROPOSED BUDGET SUMMARY

A. PATTERN BOXES ARE FORMULA DRIVEN - DO NOT OVERIDE - SEE INSTRUCTIONS

FUNDING SOURCES		Other Funding	Other Funding	Other Funding	Other Funding	Other Funding	Other Funding	Program Income	TOTAL
SECURED									
ENTER TOTAL REQUEST	$74,564								$74,564

EXPENSE CATEGORY

Personnel	$49,967								$49,967
Travel	$0								$0
Operating	$574								$574
Equipment	$0								$0
Contractual/Consultant	$15,445								$15,445
Training	$0								$0
Other Expenses	$0								$0
Indirect	$8,578								$8,578
TOTAL EXPENSE	**$74,564**	$0	$0	$0	$0	$0	$0	$0	**$74,564**
These boxes should equal 0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Total Indirect Cost	$8,578

Total Agency Budget	$74,564
Percent of Subrecipient Budget	100%

B. Explain any items noted as pending:

C. Program Income Calculation:

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBAWARD

SECTION C
Budget and Financial Reporting Requirements
revised on 02/04/2021

Identify the source of funding on all printed documents purchased or produced within the scope of this subaward, using a statement similar to: "This publication (journal, article, etc.) was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 6 NH23IP922609-02-04 from The Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor The CDC."

Any activities performed under this subaward shall acknowledge the funding was provided through the Division by Grant Number 6 NH23IP922609-02-04 from The Centers for Disease Control and Prevention (CDC).

Funding Sources:	**% Funds:**
Nevada Immunization & Vaccine for Children Federal Grant (CDC) COVID-19 Funds	100%

Subrecipient agrees to adhere to the following budget:

Applicant Name: Washoe County Health District

BUDGET NARRATIVE

Total Personnel Costs including fringe **Total:** **$ 69,308**

List staff, positions, percent of time to be spent on the project, rate of pay, fringe rate, and total cost to this grant.

	Annual Salary	Fringe Rate	% of Time	Months	Percent of Months worked Annual	Amount Requested
I/H RN	$64,812.80	1.750%	73.000%	21	100.00%	$48,141
I/H CHA	$49,504.00	1.750%	1.000%	21	100.00%	$504
Overtime for WCHD staff at all levels	$0.00	0.000%	0.000%	21	75.00%	$20,663

Total Fringe Cost	**$837**	**Total Salary Cost:**	**$68,471**
Total Budgeted FTE	0.74000		

Travel **Total:** **$0**

Identify staff who will travel, the purpose, frequency and projected costs. Utilize GSA rates for per diem and lodging (go to www.gsa.gov) and State rates for mileage (575.0 cents) as a guide unless the organization's policies specify lower rates for these expenses. Out-of-state travel or non-standard fares require special justification.

Out-of-State Travel **$0**

	Cost	# of Trips	# of days	# of Staff	
Justification:					
NO OUT OF STATE TRAVEL					

In-State Travel **$0**

Origin & Destination	Cost	# of Trips	# of days	# of Staff	
Mileage: (rate per mile x # of miles per r/trip) x # of trips x # of staff	$0.000	0		0	$0.00

Justification: No Travel costs

Operating **Total:** **$574**

List tangible and expendable personal property, such as office supplies, program supplies, etc. Unit cost for general items are not required. Listing of typical or anticipated program supplies should be included. If providing meals, snacks, or basic nutrition, include these costs here.

Printing	Client forms and education	573.60

Justification: Operating Costs

Equipment **Total:** **$0**

List Equipment purchase or lease costing $5,000 or more and justify these expenditures. Also list any computers or computer-related equipment to be purchased regardless of cost. All other equipment costing less than $5,000 should be listed under Supplies.

Describe equipment	$0.00

Contractual **$74,891**

Identify project workers who are not regular employees of the organization. Include costs of labor, travel, per diem, or other costs. Collaborative projects with multiple partners should expand this category to break out personnel, travel, equipment, etc., for each site. Sub-awards or mini-grants that are a component of a larger project or program may be included here but require special justification as to the merits of the applicant serving as a "pass-through" entity, and its capacity to do so.

Name of Contractor or Subrecipient: Temporary staffing Services **Total** **$74,891**

Period of Performance: October 01, 2020 - June 30, 2022

Scope of Work: Staff to complete required data entry into EHR system & WebIZ

Budget

Personnel			$30,781.00
Travel			$0.00
Total Budget	-	-	$30,781.00

Method of Accountability:

Technology	EHR subscription fees/access for multiple staff	$ 44,110.00

Training **Total:** **$0**

List all cost associated with Training, including justification of expenditures.

Describe training	$0.00

Other **Total:** **$0**

Identify and justify these expenditures, which can include virtually any relevant expenditure associated with the project, such as audit costs, car insurance, client transportation, etc. Stipends or scholarships that are a component of a larger project or program may be included here but require special justification.

Justification:

TOTAL DIRECT CHARGES			**$ 144,773**
Indirect Charges	**Indirect Rate:**	**13.000%**	**$18,820**
Indirect Methodology: 13% indirect			
TOTAL BUDGET	**Total:**		**$163,593**

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBAWARD

Applicant Name: Washoe County Health District **Form 2**

PROPOSED BUDGET SUMMARY

A. PATTERN BOXES ARE FORMULA DRIVEN - DO NOT OVERIDE - SEE INSTRUCTIONS

FUNDING SOURCES		Other Funding	Other Funding	Other Funding	Other Funding	Other Funding	Other Funding	Program Income	TOTAL
SECURED									
ENTER TOTAL REQUEST	$163,593								$163,593
EXPENSE CATEGORY									
Personnel	$69,308								$69,308
Travel	$0								$0
Operating	$574								$574
Equipment	$0								$0
Contractual/Consultant	$74,891								$74,891
Training	$0								$0
Other Expenses	$0								$0
Indirect	$18,820								$18,820
TOTAL EXPENSE	$163,593	$0	$0	$0	$0	$0	$0	$0	$163,593
These boxes should equal 0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Total Indirect Cost	$18,820

Total Agency Budget	$163,593
Percent of Subrecipient Budget	100%

B. Explain any items noted as pending:

C. Program Income Calculation:

- Department of Health and Human Services policy allows no more than 10% flexibility of the total not to exceed amount of the subaward, within the approved Scope of Work/Budget. Subrecipient will obtain written permission to redistribute funds within categories. **Note: the redistribution cannot alter the total not to exceed amount of the subaward. Modifications in excess of 10% require a formal amendment.**

- Equipment purchased with these funds belongs to the federal program from which this funding was appropriated and shall be returned to the program upon termination of this agreement.

- Travel expenses, per diem, and other related expenses must conform to the procedures and rates allowed for State officers and employees. It is the Policy of the Board of Examiners to restrict contractors/ Subrecipients to the same rates and procedures allowed State Employees. The State of Nevada reimburses at rates comparable to the rates established by the US General Services Administration, with some exceptions (State Administrative Manual 0200.0 and 0320.0).

The Subrecipient agrees:
To request reimbursement according to the schedule specified below for the actual expenses incurred related to the Scope of Work during the subaward period.

- Nevada State Immunization Program must receive Requests for Reimbursement no later than the fifteenth (15th) day of each month for the prior month's actual expenses;
- **Total reimbursement through this subaward will not exceed $163,593.00;**
- Requests for Reimbursement will be accompanied by supporting documentation, including a line item description of expenses incurred;
- Reimbursements will not be processed without all **mandatory reporting documents:**
    - Request for Reimbursement Form
    - Reimbursement Worksheet
    - Receipts for supplies, travel, equipment, and other items purchased
- Reimbursement is based on actual expenditures incurred during the period being reported. The Reimbursement Worksheet supplied should be used to tabulate and summarize the expenses by grant category and should be submitted with the other documents as described below;
    - Submit one hard copy via postal mail of original, signed Request for Reimbursement, Reimbursement Worksheet, and copies of receipts;
- Additional expenditure detail will be provided upon request from the Division.

Additionally, the Subrecipient agrees to provide:

- A complete financial accounting of all expenditures to the Department within 30 days of the CLOSE OF THE SUBAWARD PERIOD. Any un-obligated funds shall be returned to the Department at that time, or if not already requested, shall be deducted from the final award.
- Any work performed after the BUDGET PERIOD will not be reimbursed.
- If a Request for Reimbursement (RFR) is received after the 45-day closing period, the Department may not be able to provide reimbursement.
- If a credit is owed to the Department after the 45-day closing period, the funds must be returned to the Department within 30 days of identification.

The Department agrees:
- To provide technical assistance to subgrantee, upon request;
- Reimburse subgrantee for Scope of Work accomplished per subgrant upon proper documentation from subgrantee;
- Submit reimbursement request to the Division of Public and Behavioral Health Fiscal Services within five (5) business days but only upon receipt of all mandatory reporting documentation; and
- The Division reserves the right to hold reimbursement under this subaward until any delinquent forms, reports, and expenditure documentation are submitted to and accepted by the Division.

Both parties agree:
- Site visits will be conducted by the Division of Public and Behavioral Health on an annual basis, during this grant period, to ensure grant compliance. The subrecipient monitoring program is designed to meet the federal requirement of Subpart F—Audit Requirements as outlined in Title 2 CFR-Part 200. During the Site Visit the administrative, programmatic and financial activities related to the administration and compliance requirements of federal and state laws, regulations and grant programs will be reviewed.
- The Subrecipient will, in the performance of the Scope of Work specified in this subaward, perform functions and/or activities that could involve confidential information; therefore, the Subrecipient is requested to fill out Section G, which is specific to this subaward, and will be in effect for the term of this subaward.
- All reports of expenditures and requests for reimbursement processed by the Department are SUBJECT TO AUDIT.
- This subaward agreement may be TERMINATED by either party prior to the date set forth on the Notice of Subaward, provided the termination shall not be effective until 30 days after a party has served written notice upon the other party. This agreement may be terminated by mutual consent of both parties or unilaterally by either party without cause. The parties expressly agree that this Agreement shall be terminated immediately if for any reason the Department, state, and/or federal funding ability to satisfy this Agreement is withdrawn, limited, or impaired.

Financial Reporting Requirements
- A Request for Reimbursement is due monthly, based on the terms of the subaward agreement, no later than the 15th of the month.
- Reimbursement is based on actual expenditures incurred during the period being reported.
- Payment will not be processed without all reporting being current.
- Reimbursement may only be claimed for expenditures approved within the Notice of Subaward.

Agency Ref. #: SG 2502
Budget Account: 3213
GL: 8516
Draw #:

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBAWARD
Exhibit A: SECTION D

Request for Reimbursement

Program Name: Nevada State of Immunization Program Bureau of Child, Family & Community Wellness	**Subrecipient Name**: Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite 210 Carson City, NV 89706-2009	**Address**: 1001 E. 9th St. Reno, NV 89512-2845
Subaward Period: 10/01/2020-06/30/2021	**Subrecipient's**: EIN: 88-6000138 Vendor #: T40283400 Q

FINANCIAL REPORT AND REQUEST FOR REIMBURSEMENT

(must be accompanied by expenditure report/back-up)

Month(s) Calendar year

Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year to Date Total	E Budget Balance	F Percent Expended
1. Personnel	$49,967.00	$0.00	$0.00	$0.00	$49,967.00	0.0%
2. Travel	$0.00	$0.00	$0.00	$0.00	$0.00	-
3. Operating	$574.00	$0.00	$0.00	$0.00	$574.00	0.0%
4. Equipment	$0.00	$0.00	$0.00	$0.00	$0.00	-
5. Contractual/Consultant	$15,445.00	$0.00	$0.00	$0.00	$15,445.00	0.0%
6. Training	$0.00	$0.00	$0.00	$0.00	$0.00	-
7. Other	$0.00	$0.00	$0.00	$0.00	$0.00	-
8. Indirect	$8,578.00	$0.00	$0.00	$0.00	$8,578.00	0.0%
Total	**$74,564.00**	**$0.00**	**$0.00**	**$0.00**	**$74,564.00**	0.0%

MATCH REPORTING	Approved Match Budget	Total Prior Reported Match	Current Match Reported	Year to Date Total	Match Balance	Percent Completed
INSERT MONTH/QUARTER	$0.00	$0.00	$0.00	$0.00	$0.00	-

I, a duly authorized signatory for the applicant, certify to the best of my knowledge and belief that this report is true, complete and accurate; that the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the grant award; and that the amount of this request is not in excess of current needs or, cumulatively for the grant term, in excess of the total approved grant award. I am aware that any false, fictitious or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims, or otherwise. I verify that the cost allocation and backup documentation attached is correct.

Authorized Signature Title Date

FOR Department USE ONLY

Is program contact required? ____ Yes _____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____

Scope of Work review/approval date: _____

Chief (as required): _____ _____
Date

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF SUBAWARD
SECTION D
Request for Reimbursement
revised on 02/04/2021

Agency Ref #: **SG 25024-1**
Budget Account: 3213
GL: 8516
Draw #:

Program Name: Nevada State of Immunization Program Bureau of Child, Family & Community Wellness	**Subrecipient Name:** Washoe County Health District (WCHD)
Address: 4150 Technology Way, Suite 210 Carson City, NV 89706-2009	**Address:** 1001 E. 9th St. Reno, NV 89512-2845
Subaward Period: **10/01/2020-06/30/2022**	**Subrecipient's:** **EIN: 88-6000138** **Vendor #: T40283400 Q**

FINANCIAL REPORT AND REQUEST FOR FUNDS

(must be accompanied by expenditure report/back-up)

Month(s) **Calendar year**

Approved Budget Category	A Approved Budget	B Total Prior Requests	C Current Request	D Year to Date Total	E Budget Balance	F Percent Expended
1. Personnel	$69,308.00	$0.00	$0.00	$0.00	$69,308.00	0.0%
2. Travel	$0.00	$0.00	$0.00	$0.00	$0.00	-
3. Operating	$574.00	$0.00	$0.00	$0.00	$574.00	0.0%
4. Equipment	$0.00	$0.00	$0.00	$0.00	$0.00	-
5. Contractual/Consultant	$74,891.00	$0.00	$0.00	$0.00	$74,891.00	0.0%
6. Training	$0.00	$0.00	$0.00	$0.00	$0.00	-
7. Other	$0.00	$0.00	$0.00	$0.00	$0.00	-
8. Indirect	$18,820.00	$0.00	$0.00	$0.00	$18,820.00	0.0%
Total	**$163,593.00**	**$0.00**	**$0.00**	**$0.00**	**$163,593.00**	0.0%

I, a duty authorized signatory for the applicant, certify to the best of my knowledge and belief that this report is true, complete and accurate; that the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the grant award; and that the amount of this request is not in excess of current needs or, cumulatively for the grant term, in excess of the total approved grant award. I am aware that any false, fictitious or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims, or otherwise. I verify that the cost allocation and backup documentation attached is correct.

Authorized Signature | Title | Date

FOR DIVISION USE ONLY

Is program contact required? ____ Yes ____ No Contact Person: _____

Reason for contact: _____

Fiscal review/approval date: _____

Scope of Work review/approval date: _____

ASO or Bureau Chief (as required): _____ _____ Date