RESOLUTION NO. 434-98

A RESOLUTION COMMITTING LOCAL MATCH AND DESIGNATING AN AUTHORIZED REPRESENTATIVE FOR THE HAZARD MITIGATION PLANNING ASSISTANCE GRANT

WHEREAS, the County of Mitchell, Iowa, would like to develop a hazard mitigation plan and desires to obtain a Planning Grant from the Federal Emergency Management Agency (FEMA); and

WHEREAS, the County understands the importance of lowering risks and reducing the effects of disasters by identifying likely future hazards and planning for solutions to lessen their economic consequences; and

WHEREAS, the County recognizes the fact that a planning grant from FEMA is a 75% federal / 25% nonfederal matching source; and

WHEREAS, the County desires to designate an authorized representative to work on the County's behalf in completing this important endeavor;

NOW, THEREFORE, It Is Resolved by the Board of Supervisors of Mitchell County as follows:

Section 1. The County shall form an agreement with the Iowa Emergency Management Division (IEMD) and FEMA as to the date that said 25% shall be available to match the federal funds awarded and agrees to provide $900 of local monies to be used as matching funds for the approved planning grant as outlined in the grant application. Of this amount, only one half may be provided from in-kind contributions.

Section 2. The County hereby authorizes Joe Myhre, Executive Director of the North Iowa Area Council of Governments (NIACOG), to execute on behalf of the County, the Hazard Mitigation Planning Project Grant and to file the application with the IEMD for the purpose of obtaining Federal financial assistance.

Authorized Representative Signature: _____

PASSED AND APPROVED THIS 31st DAY OF March, 1998.

Kelly McCarthy
Chair, Board of Supervisors

ATTEST:

Sandra Heckstein
County Auditor

APPLICATION FOR HAZARD MITIGATION PLANNING ASSISTANCE PLANNING GRANT

Part I - Applicant Information

A. Applicant: City of _____
County of Mitchell

B. Municipal / County Government

C. Federal Tax ID Number: 42-6005076

D. Local Point of Contact:
Name: Sandra Heckstein
Title: Mitchell County Auditor
Address: 508 State Street
Osage, Iowa 50461-1229
Phone: 515-732-5861
Fax: 515-732-5218

E. Local Alternate Point of Contact:
Name: Ray Huftalin
Title: Emergency Management Director
Address: 508 State Street
Osage, Iowa 50461-1229
Phone: 515-732-5872
Fax: _____

F. Applicant's Authorized Representative:
Joe Myhre
NIACOG
121 Third St. N.W.
Mason City, Iowa 50401
Phone: 515-423-0491
Fax: 515-423-1637

G. Participating in the National Flood Insurance Program (NFIP) and in good standing:

_____ Yes X No

Part II - Planning Information

A. Date of Submission: May 1, 1998

B. Planning Narrative - See Attached Scope of Work

Part III - Revised Planning Information

AN AGREEMENT BETWEEN
THE NORTH IOWA AREA COUNCIL OF GOVERNMENTS
AND
THE COUNTY OF MITCHELL, IOWA

This Agreement is entered into by, and between, the North Iowa Area Council of Governments (herein referred to as **THE AGENCY**) and the County of Mitchell, Iowa, (hereinafter referred to as **THE COUNTY**) for the provision of services by **THE AGENCY**, on behalf of **THE COUNTY**, as described herein.

It is hereby agreed by **THE AGENCY** and **THE COUNTY** as follows:

Section 1. Authority of Agreement

The Board of Supervisors of Mitchell County, Iowa has authorized the Chairperson to sign an agreement retaining the services of **THE AGENCY**, as herein described, and agrees to make restitution to **THE AGENCY** as prescribed herein provided Hazard Mitigation Planning Grant funds are successfully secured on behalf of Mitchell County.

Section 2. Scope of Services

THE AGENCY will provide technical assistance to **THE COUNTY**, or representatives thereof as specified herein, for assembling, preparing and publishing of a local **HAZARD MITIGATION PLAN** (hereinafter referred to as the **PLAN**) in accordance with the requirements set forth by the Iowa Department of Defense Emergency Management Division.

Section 3. Meetings

THE AGENCY agrees to meet with **THE COUNTY'S** representatives on a limited basis, as described herein, concerning the ongoing process of assembling needed materials and information necessary in an undertaking of this nature, as well as reviewing draft proposals of the **PLAN. THE AGENCY** agrees to present the **PLAN** to the Board of Supervisors at a public hearing which must be held prior to the adoption of the **PLAN**.

Section 4. Termination of Contract

THE COUNTY or **THE AGENCY** shall have the right to terminate this contract upon written notice with reasons for such termination included in said notice. Upon cancellation, **THE COUNTY** will be responsible for only those costs incurred by **THE AGENCY** up to, and including, the day such notice of termination is received in the offices of either **THE AGENCY** or **THE COUNTY.**

Section 5. Cost of Services

The cost of services provided by **THE AGENCY** to **THE COUNTY** shall not exceed 25% of the total project cost. The fee covers related expenses, such as mileage for meetings, printing, postage, etc. Costs incurred for services provided by **THE AGENCY** in the **PLAN** project for **THE COUNTY** will be billed upon completion with payment by **THE COUNTY** due within thirty (30) days of the billing date. The cost to **THE COUNTY** for the services described in Section 2, 3 and 7 shall not exceed nine hundred dollars ($900), of which four hundred fifty dollars ($450) may be in the form of an in-kind match.

Section 6. Preparation of Copies

The number of copies of the proposed **PLAN** that **THE AGENCY** will provide to **THE COUNTY**, beginning with the first draft and continuing until passage or acceptance of the document (unless otherwise specified), shall not exceed five (5) copies.

Additional copies of the **PLAN**, for either draft or final copies, will be assessed a price equal to the sum of all pages in the document charged at five cents ($.05) per page.

Section 7. Period of Conditional Support

THE AGENCY will provide **THE COUNTY** a period of conditional support service concerning the adopted **PLAN**. The support service will be limited to items found in the final documents after its adoption which are found to be inaccurate. This support will not include items which are new in content and will not include revisions to the documents which are desired by **THE COUNTY** after their original adoption or acceptance date. Revisions to the **PLAN** may be done by **THE AGENCY** on an hourly charge basis.

The period of conditional support service shall not exceed one (1) year after the passage of the **PLAN.**

This agreement is hereby authorized and entered into by:

Betty McCarty
Chair, Board of Supervisors, Mitchell County — Date 3/31/98

Joe Mulhern
NIACOG Executive Director — Date 4/28/98

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Authorized Representative Signature: Joe Myhre

PASSED AND APPROVED THIS 31st DAY OF March, 1998.

Kelly McCarthy
Chair, Board of Supervisors

ATTEST:

Sandra Heckstein
County Auditor

MITCHELL COUNTY HOME HEALTH CARE
616 N 8TH ST
OSAGE, IA 50461
PH:(515) 732-6150 / FAX:(515) 732-6151

090198

FISCAL YEAR 99 WAGES AND BENEFITS REVISION AS OF 082998 (fy98w&b)
********************(Effective with pay period 082998-091198)****************************

MILEAGE FOR ALL EMPLOYEES REIMBURSED AT 28 CENTS PER MILE.

HOURLY EMPLOYEES:	STATUS	PER HOUR	VACATION YEAR	SICK MONTH	VACATION DAY	HOLIDAY DAY
Thelma Scharper	PT-36	$9.32	103.25 hrs	10.5 hrs	8 hrs	7 hrs
Paula Klein	PT-36	$7.43	40 hrs	10.5 hrs	8 hrs	7 hrs
Barbara Jeffries	FT	$7.43	40 hrs	12 hrs	8 hrs	8 hrs
Sheila Adams	PT-15	$8.05	30 hrs	4.5 hrs	3 hrs	3 hrs
Grace Barenz	PT-32	$8.29	249 hrs	9 hrs	8 hrs	6 hrs
Jean Bensend	PT-15	$8.29	27 hrs	4.5 hrs	3 hrs	3 hrs
Karon Clark	PT-30	$8.29	33.5 hrs	9 hrs	6 hrs	6 hrs
Carol Clark	PT-25	$8.29	95 hrs	7.5 hrs	5 hrs	5 hrs
Brenda Dohlman	PT-10	$7.40	4 hrs	3 hrs	2 hrs	2 hrs
Joni Graves	TEMP	$7.80	NONE			
Audrey Myhre	PT-20	$8.29	44 hrs	6 hrs	4 hrs	4 hrs
Marcia Smith	PT-20	$8.05	36 hrs	6 hrs	4 hrs	4 hrs

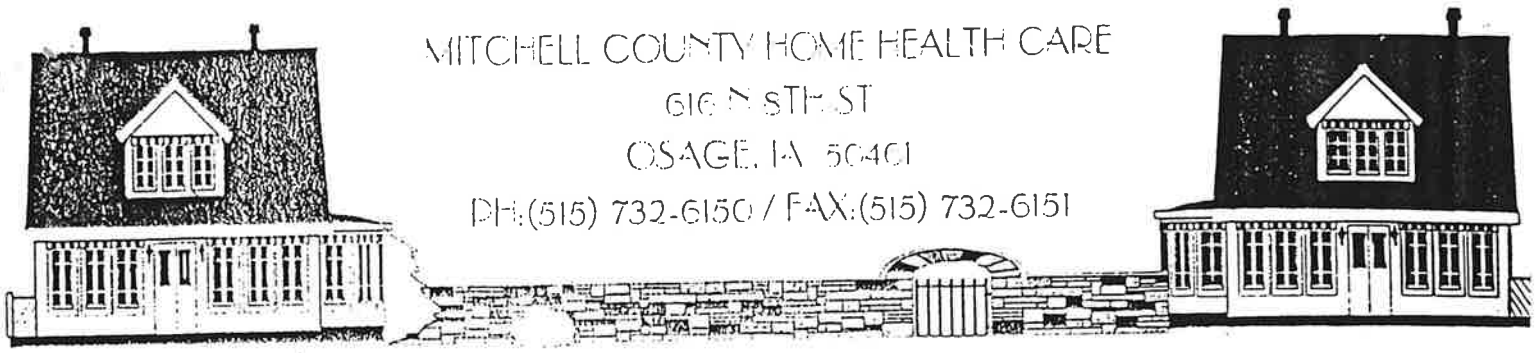
SALARIED EMPLOYEES (exempt) WITH HOME VISIT PAY FORMULA:

	STATUS	PAY PERIOD	HOURLY	HV PAY	VACATION YEAR	SICK MONTH	VACATION DAY	HOLIDAY DAY
30 Carolyn Johnson	PT-32	$1002.24	$15.66	$20.82	132 hrs	9 hrs	8 hrs	8 hrs
10 Donna Marreel	PT-32	$1002.24	$15.66	$20.82	186 hrs	9 hrs	8 hrs	8 hrs
17 Debbie Farkas	PT-32	$1002.24	$15.66	$20.82	106.5 hrs	9 hrs	8 hrs	8 hrs
19 Rosalie Rush	PT-20	$ 556.00	$13.90	$18.48	63.75 hrs	6 hrs	8 hrs	8 hrs
21 Peg Denner	PT-10	$ 312.72	$13.03	$17.32	29.25 hrs	3 hrs	8 hrs	8 hrs
25 Kay Comisky	PT-32	$ 518.21*	$13.46	$17.90	53.75 hrs*	9 hrs	8 hrs	8 hrs
16 Kay Comisky		$ 343.23**			31 hrs**			
	TOTAL....	$ 861.44		TOTAL...	84.75 hrs			

* Kay Comisky....General Budget
** Kay Comisky....Senior Health Clinic Budget

325 Shirley Stille	FT	$1556.04	$19.45		72 hrs	12 hrs	8 hrs	8 hrs

Shirley Stille RN 090198



MITCHELL COUNTY HOME HEALTH CARE
616 N 5TH ST
OSAGE, IA 50461
PH:(515) 732-6150 / FAX:(515) 732-6151

110698

FISCAL YEAR 99 WAGES AND BENEFITS REVISION AS OF 110698 (fy98w&b)
********************(Effective with pay period #10: 102498-110698)*****************************

MILEAGE FOR ALL EMPLOYEES REIMBURSED AT 28 CENTS PER MILE.

HOURLY EMPLOYEES:	STATUS	PER HOUR	SICK MONTH	VACATION DAY	HOLIDAY DAY
Thelma Scharper	PT-36	$9.60	10.5 hrs	8 hrs	8 hrs
Paula Klein	PT-36	$7.99	10.5 hrs	8 hrs	8 hrs
Barbara Jeffries	FT	$7.66	12 hrs	8 hrs	8 hrs
Sheila Adams	PT-15	$8.54	4.5 hrs	3 hrs	3 hrs
Grace Barenz	PT-32	$8.54	9 hrs	8 hrs	8 hrs
Jean Bensend	PT-15	$8.54	4.5 hrs	3 hrs	3 hrs
Carol Clark	PT-25	$8.54	7.5 hrs	5 hrs	5 hrs
Brenda Dohlman	PT-10	$8.04	3 hrs	2 hrs	2 hrs
Joni Graves	TEMP	$8.04	NONE----------		
Audrey Myhre	PT-20	$8.54	6 hrs	4 hrs	4 hrs
Marcia Smith	PT-20	$8.54	6 hrs	4 hrs	4 hrs

SALARIED EMPLOYEES (exempt) WITH HOME VISIT PAY FORMULA:

	STATUS	PAY PERIOD	HOURLY	HV PAY	SICK MONTH	VACATION DAY	HOLIDAY DAY
Carolyn Johnson	PT-32	$1032.32	$16.13	$21.45	9 hrs	8 hrs	8 hrs
Donna Marreel	PT-32	$1032.32	$16.13	$21.45	9 hrs	8 hrs	8 hrs
Debbie Farkas	PT-32	$1032.32	$16.13	$21.45	9 hrs	8 hrs	8 hrs
Rosalie Rush	PT-20	$ 590.40	$14.76	$19.63	6 hrs	8 hrs	8 hrs
Peg Denner	PT-10	$ 322.32	$13.43	$17.86	3 hrs	8 hrs	8 hrs
Kay Comisky	PT-32	$ 533.99*	$13.87	$18.44	9 hrs	8 hrs	8 hrs
Kay Comisky		$ 353.68**					
		TOTAL.... $ 887.68					

* Kay Comisky....General Budget
** Kay Comisky....Senior Health Clinic Budget

Shirley Stille	FT	$1602.73	$20.03	12 hrs	8 hrs	8 hrs

changes highlighted Shirley Stille RN Adm 110698