Department of State Health Services
Attn: Client Services Contracting Unit,
Vendor Coordinator
Fax: 512/458-7351
E-mail: cscu.customersupport@dshs.state.tx.us

VENDOR/User INFORMATION NEW ____ or Updated Information ____

1a. Legal name **of Other Party (OP)** as it appears on documentation from IRS, Comptroller, or Secretary of State. This is the name that will appear on the contract document either as "Contractor" or by name. If using an assumed name, please attach documentation from Office of the Secretary of State or County Attorney.

1b**. OP Address** (Include Street and Mailing Addresses, City, County, State and 9 digit Zip Code):

1c. **PAYEE Name and Mailing Address and 9 digit Zip Code** (as it should appear on financial instruments and remittances):

1d. Federal Employer Identification No. [FEIN] (9 digit), name and Social Security Number (SSN), if individual, or State of Texas Comptroller Vendor Identification No. (14 digit).
NOTE: Use of SSN may result in it becoming part of documents that are subject to the Public Information Act. DSHS will not redact SSN when releasing information to the public.

1e**. Mail code**, if known (3 digits):

1f. DUNS Number (9 digits - required for subrecipient contractors):
For instructions to obtain a DUNS refer to FFATA Guidance at http://www.dshs.state.tx.us/grants/gen-prov.shtm

2. TYPE OF ENTITY (enter appropriate letter in box): ☐ Is your entity certified as a HUB? ☐ Yes ☐ No

A. City or County (Governmental Entity)
B. State Agency
C. State Institution of Higher Learning
D. Other Political Subdivision
E. Texas Non-profit Corporation *
F. Texas For Profit Corporation*
G. Professional Association*
H. Regular Association
I. Sole Proprietor
J. Individual
K. Partnership**
L. Limited Partnership**
M. Out-of-State Corp
N. Other ***

*Please provide 10-digit charter or file number assigned by the Secretary of State: _____

** Please provide the name and SSN or FEIN of each partner._____ _____

***If "Other", specify. _____

3a. Legal name of person or entity authorized to contract with Department of State Health Services.

3b. Typed **Name & Title of Person** *Authorized to Sign Contracts*:	3b. Telephone
3c. Typed **Name & Title** of Contact Person (Contract Documents and Correspondence)	3c. Telephone
3d. Contact Person's E-mail Address	
4a. Signature of person *Authorized to Sign Contracts* :	4b. Date