



Department of State Health Services

**FORM A: FACE PAGE**

*Proposal for Financial Assistance [RFP Number]*

*This form requests basic information about the respondent and project, including the signature of the authorized representative. The face page is the cover page of the proposal and must be completed in its entirety.*

**RESPONDENT INFORMATION**

1) LEGAL BUSINESS NAME:

2) MAILING Address Information (include mailing address, street, city, county, state and zip code): Check if address change

3) PAYEE Name and Mailing Address (if different from above): Check if address change

4) Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or Social Security Number (9 digit) :

*\*The respondent acknowledges, understands and agrees that the respondent's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.*

5) TYPE OF ENTITY (check all that apply):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> City                        | <input type="checkbox"/> Nonprofit Organization*      | <input type="checkbox"/> Individual                                      |
| <input type="checkbox"/> County                      | <input type="checkbox"/> For Profit Organization*     | <input type="checkbox"/> FQHC  |
| <input type="checkbox"/> Other Political Subdivision | <input type="checkbox"/> HUB Certified                | <input type="checkbox"/> State Controlled Institution of Higher Learning |
| <input type="checkbox"/> State Agency                | <input type="checkbox"/> Community-Based Organization | <input type="checkbox"/> Hospital  |
| <input type="checkbox"/> Indian Tribe                | <input type="checkbox"/> Minority Organization        | <input type="checkbox"/> Private   |
|  | <input type="checkbox"/> Faith Based (Nonprofit Org)  | <input type="checkbox"/> Other (specify): _____                          |

*\*If incorporated, provide 10-digit charter number assigned by Secretary of State:*

6) PROPOSED BUDGET PERIOD: Start Date: End Date:

7) COUNTIES SERVED BY PROJECT:

8) AMOUNT OF FUNDING REQUESTED:

9) PROJECTED EXPENDITURES

Does respondent's projected state or federal expenditures exceed \$500,000 for respondent's current fiscal year (excluding amount requested in line 8 above)? \*\*

Yes  No

*\*\*Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.*

10) PROJECT CONTACT PERSON

Name:  
Phone:  
Fax:  
E-mail:

11) FINANCIAL OFFICER

Name:  
Phone:  
Fax:  
E-mail:

The facts affirmed by me in this proposal are truthful and I warrant the respondent is in compliance with the assurances and certifications contained in **APPENDIX A: DSHS Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the respondent and I (the person signing below) am authorized to represent the respondent.

12) AUTHORIZED REPRESENTATIVE Check if change

Name:  
Title:  
Phone:  
Fax:  
E-mail:

13) SIGNATURE OF AUTHORIZED REPRESENTATIVE

14) DATE

## FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the respondent and the proposed project with the Department of State Health Services (DSHS), including the signature of the authorized representative. It is the cover page of the proposal and is required to be completed. Signature affirms the facts contained in the respondent's response are truthful and the respondent is in compliance with the assurances and certifications contained in **APPENDIX A: DSHS Assurances and Certifications** and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below to complete the face page form and return with the respondent's proposal.

- 1) **LEGAL BUSINESS NAME** - Enter the legal name of the respondent.
- 2) **MAILING ADDRESS INFORMATION** - Enter the respondent's complete physical address and mailing address, city, county, state, and zip code.
- 3) **PAYEE NAME AND MAILING ADDRESS** - Payee – Entity involved in a contractual relationship with respondent to receive payment for services rendered by respondent and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address if PAYEE is different from the respondent. The PAYEE is the corporation, entity or vendor who will be receiving payments.
- 4) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID/SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit). \*The respondent acknowledges, understands and agrees the respondent's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.
- 5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the Comptroller's Texas Procurement and Support Services or another entity.

MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

- 6) **PROPOSED BUDGET PERIOD** - Enter the budget period for this proposal. Budget period is defined in the RFP.
- 7) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.
- 8) **AMOUNT OF FUNDING REQUESTED** - Enter the amount of funding requested from DSHS for proposed project activities (not including possible renewals). This amount must match column (1) row K from FORM I: BUDGET SUMMARY.
- 9) **PROJECTED EXPENDITURES** - If respondent's projected state or federal expenditures exceed \$500,000 for respondent's current fiscal year, respondent must arrange for a financial compliance audit (Single Audit).
- 10) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.
- 11) **FINANCIAL OFFICER** - Enter the name, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.
- 12) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and e-mail address of the person authorized to represent the respondent. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.
- 13) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the respondent must sign in this blank.
- 14) **DATE** - Enter the date the authorized representative signed this form.