Memorandum

TO: **Administrative Agency Executive Directors**
Administrative Agency Contact Persons

FROM: **Pamela Mann, Contract Manager**
Contract Management Unit
Division of Prevention and Preparedness

DATE: **May 16, 2012**

SUBJECT: **State Services Renewal Request for Fiscal Year 2013 (09/01/12 – 08/31/2013)**

Enclosed are the documents required for your agency's State Services (HIV/SRVS) contract renewal with the Department of State Health Services (DSHS) for the period September 1, 2012 through August 31, 2013. This document will be posted on the HIV/STD Program's website at: http://www.dshs.state.tx.us/hivstd/funding/default.shtm. Instructions for completing the forms are included below. If you have questions, please contact Pamela Mann at (512) 776-6539.

The renewal budget templates and forms are attached to this memorandum.

If you have questions, please contact Pamela Mann, Contract Manager, at (512) 458-7111 ext. 6539.

Please note the following requirements for Fiscal Year 2013 Contract Renewal:

- Complete Form A Face Page
- Complete Form B Contact Information Page
- Prepare a 12 month budget for this contract renewal period (09/01/12 – 8/31/2013). Budget forms are attached, complete all tabs as necessary.

(*Table 1 and Table 2 are not required at this time.)

INSTRUCTIONS FOR SUBMISSION

Please submit one (1) electronic copy of the required contract renewal forms to the email address listed below and one (1) electronic copy to your Public Health Regional HIV/STD Program Manager on or before 5:00 pm Friday May 25, 2012. The signed face page must be scanned in as a .pdf file and sent to:

Hiv-srvscontracts@dshs.state.tx.us
Contract Management Unit
Department of State Health Services

Hard copies of the renewal application is not required for submission.

FY 2013
(09/01/2012 – 08/31-2012)
Renewal Guidance For State Services

http://www.dshs.state.tx.us/hivstd/funding/default.shtm

Issue Date: May 16, 2012
Due Date: May 25, 2012

Contract Management Unit
Department of State Health Services
1100 W. 49th Street
Austin, Texas 78756-3199

David L. Lakey, M.D.
Commissioner

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ORGANIZATION AND CONTENT

SEE EXCEL SPREADSHEETS ATTACHED FOR FOLLOWING FORMS:

- BUDGET SUMMARY TEMPLATE INCLUDING CATEGORICAL BUDGET JUSTIFICATIONS TABS

Department of State Health Services (DSHS)

FORM A: FACE PAGE -This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the renewal and shall be completed in its entirety. Signature of face page certifies to all DSHS and program assurances listed in this renewal document.

RESPONDENT INFORMATION
1) LEGAL BUSINESS NAME:
2) MAILING Address Information (include mailing address, street, city, county, state and 9-digit zip code): **Check if address change** ☐
3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above): **Check if address change** ☐
4) DUNS Number (9-digit) required if receiving federal funds:
5) Federal Tax ID No. (9-digit), **State of Texas Comptroller Vendor ID Number** (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.***

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

☐ City	☐ Nonprofit Organization*	☐ Individual
☐ County	☐ For Profit Organization*	☐ Federally Qualified Health Centers
☐ Other Political Subdivision	☐ HUB Certified	☐ State Controlled Institution of Higher Learning
☐ State Agency	☐ Community-Based Organization	☐ Hospital
☐ Indian Tribe	☐ Minority Organization	☐ Private
	☐ Faith Based (Nonprofit Org)	☐ Other (specify): _____

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

7) PROPOSED BUDGET PERIOD: **Start Date:** 09/01/2012 **End Date:** 08/31/2013

8) COUNTIES SERVED BY PROJECT:

9) AMOUNT OF FUNDING REQUESTED:

10) PROJECTED EXPENDITURES

Does respondent's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for respondent's current fiscal year (excluding amount requested in line 9 above)? **

Yes ☐ No ☐

***Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.*

11) PROJECT CONTACT PERSON

Name:
Phone:
Fax:
Email:

12) FINANCIAL OFFICER

Name:
Phone:
Fax:
Email:

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 B: 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.

13) AUTHORIZED REPRESENTATIVE **Check if change** ☐

Name:
Title:
Phone:
Fax:
Email:

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

15) DATE

FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the DSHS, including the signature of the authorized representative. It is the cover page of the renewal application and is required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original DSHS contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

1) **LEGAL BUSINESS NAME** - Enter the legal name of the applicant.

2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete physical address and mailing address, city, county, state, and 9-digit zip code.

3) **PAYEE NAME AND MAILING ADDRESS** - Payee – Entity involved in a contractual relationship with applicant to receive payment for services rendered by applicant and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address, including 9-digit zip code, if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) **DUNS Number** – 9- digit Dun and Bradstreet Data Universal Numbering System (DUNS) number. . This number is required if receiving **ANY** federal funds and can be obtained at: http://fedgov.dnb.com/webform

5) **FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The applicant acknowledges, understands and agrees the applicant's choice to use a social security number as its vendor identification number for the contract, may result in the social security number being made public via state open records requests.

6) **TYPE OF ENTITY** - Check the type of entity as defined by the Secretary of State at http://www.sos.state.tx.us/corp/businessstructure.shtml and/or the Texas State Comptroller at https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf and check all other boxes that describe the entity.

   Historically Underutilized Business**:** A minority or women-owned business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. (http://www.window.state.tx.us/procurement/prog/hub/)
   State Agency**:** an agency of the State of Texas as defined in Texas Government Code §2056.001.ii
   Institutions of higher education as defined by §61.003 of the Education Code.
   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.

7) **PROPOSED BUDGET PERIOD** - Budget period for this renewal application has been entered for you.

8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.

9) **AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding per the allocation given from DSHS for proposed project activities (not including possible renewals). This amount must match column (1) row K from the BUDGET SUMMARY used for cost reimbursement budgets.

10) **PROJECTED EXPENDITURES** - If applicant's projected federal expenditures exceed $500,000 or its projected state expenditures exceed $500,000 for applicant's current fiscal year, applicant must arrange for a financial compliance audit (Single Audit).

11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and email address of the person responsible for the proposed project.

12) **FINANCIAL OFFICER** - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.

13) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and email address of the person authorized to represent the applicant. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.

14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant must sign in this blank.

15) **DATE** - Enter the date the authorized representative signed this form.

FORM B: CONTACT PERSON INFORMATION

Legal Name of Applicant: _____

This form provides information about the appropriate program contacts in the applicant's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please notify, Pamela Mann, Contract Manager, in writing.

Executive Director: _____ **Title:** _____ **Phone:** _____ Ext. _____ **Fax:** _____ **E-mail:** _____	**Mailing Address (incl. street, city, county, state, & zip):**
Project Contact: _____ **Title:** _____ **Phone:** _____ Ext. _____ **Fax:** _____ **E-mail:** _____	**Mailing Address (incl. street, city, county, state, & zip):**
Financial Reporting Contact: _____ **Title:** _____ **Phone:** _____ Ext. _____ **Fax:** _____ **E-mail:** _____	**Mailing Address (incl. street, city, county, state, & zip):**
URS Data Manager: _____ **Title:** _____ **Phone:** _____ Ext. _____ **Fax:** _____ **E-mail:** _____	**Mailing Address (incl. street, city, county, state, & zip):**
Planning Contact: _____ **Title:** _____ **Phone:** _____ Ext. _____ **Fax:** _____ **E-mail:** _____	**Mailing Address (incl. street, city, county, state, & zip):**
Clinical Services Contact: _____ **Title:** _____ **Phone:** _____ Ext. _____ **Fax:** _____ **E-mail:** _____	**Mailing Address (incl. street, city, county, state, & zip):**