TEXAS Health and Human Services | Texas Department of State Health Services

FAX

DATE: _____

TO: Contract Management Section (CMS), ATTENTION: Coleman York

Email: coleman.york@dshs.texas.gov

FAX #: 512-776-7391

TELEPHONE#: 512-776-2189

FROM: _____

RE: FORM A: FACE PAGE - MOU

SENDER'S FAX #: _____

SENDER'S TELEPHONE #: _____

SENDER'S EMAIL ADDRESS: _____

TOTAL # OF PAGES, INCLUDING COVER: _____

NOTES:

TEXAS Health and Human Services | Texas Department of State Health Services

Department of State Health Services
FORM A: FACE PAGE

This form requests basic information about the contractor and project for the DSHS Oral Health Improvement Program. A Memorandum of Understanding (MOU) is required for the provision of preventive dental services. This Form A: Face Page must be completed in its entirety before an MOU can be executed. Please either print legibly or type in all requested information below.

CONTRACTOR INFORMATION

1) SCHOOL/BUSINESS NAME: **DSHS HSR:**

2) SCHOOL/BUSINESS Fiscal Year End (MM/DD): _____/_____

3) Mailing Address Information (Include mailing address, street, city, county, state and zip code):

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

The contractor acknowledges, understands, and agrees that the 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) DUNS Number (9-digit): _____

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

- ☐ City
- ☐ County
- ☐ Other Political Subdivision (i.e. school district)
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith Based (Nonprofit Org)
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

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

7) MOU CONTRACT PERIOD: **Start Date:** The MOU will commence on the signature date of the latter of the parties to sign the MOU. **End Date:** 8/31/2024

8) COUNTIES SERVED BY PROJECT:

9) SCHOOL/BUSINESS LEAD CONTACT PERSON FOR THE PROJECT (MUST be different from Authorized Representative):

Name:
Title:
Phone:
Fax:
Email:

10) AUTHORIZED REPRESENTATIVE (Person *authorized to* sign the MOU contract):

Name:
Title:
Phone:
Fax:
Email:

THE MOU CONTRACT WILL BE SENT ELECTRONICALLY.

TEXAS Health and Human Services | Texas Department of State Health Services

SY 2019--2020 FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the contractor and the proposed project with the Department of State Health Services (DSHS) OHIP. Please follow the instructions below to complete the *Form A: Face Page*. The MOU contract will be sent to the Contractor via email upon receipt of a completed *Face Page*.

1) **SCHOOL/BUSINESS/HEAD START CENTER NAME**: Enter the name of the School/Business/Head Start Center.

2) **DSHS Health Service Region**: The DSHS Dental Team enters the Health Service Region the School/Business/Head Start Center resides in.

3) **MAILING ADDRESS INFORMATION:** Enter the contractor's complete physical address and mailing address, city, county, state, and zip code.

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 contractor acknowledges, understands and agrees the 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) **MOU CONTRACT PERIOD**: The end date for this contract period will be 8/31/2024.

7) **COUNTIES SERVED BY PROJECT**: Enter the proposed counties served by the project.

8) **PROJECT CONTACT PERSON**: Enter the name, phone, fax, and email address of the person responsible for communicating about and/or processing the proposed project.

9.) ***AUTHORIZED REPRESENTATIVE***: Enter the name, title, phone, fax, and email address of the person *authorized to sign* the MOU. **Attention**: Make certain the individual named here as the "Authorized Representative" has official signatory authority who, in some instances, also may be the *contact* person, or a separate individual altogether.

Prior to beginning dental services, please return the completed MOU Face Page by EMAIL or FAX to:

coleman.york@dshs.texas.gov
Texas Department of State Health Services
Attention: CMS – Coleman York
FAX: 512-776-7391