**Department of State Health Services**

FORM A: FACE PAGE

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.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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:** | | | 4/1/2023 | | | | | | | | | | **End Date:** | | 3/31/2024 | | | |
| **8) COUNTIES SERVED BY PROJECT:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **9) AMOUNT OF FUNDING REQUESTED:** | | | | | | | |  | | | | | | | **11) PROJECT CONTACT PERSON** | | | | | | | | | | | | | | |
| **10) PROJECTED EXPENDITURES** | | | | | | | | | |  | | |  | |  | Name:  Phone:  Fax:  Email: | | | | |  | | | | | | | | |
| 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.* | | | | | | | | | | | | | | |  |  | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | |  |  | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | **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** | | | | | | | | | | | **14) SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | | | | | | | | | | | |
|  | Name:  Title:  Phone:  Fax:  Email: | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | **15) DATE** | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | |  | |  | | | | | | | | | | |