**Department of State Health Services**

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 application and must be completed in its entirety.

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| **APPLICANT 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)** | | **UEID Number 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 applicant acknowledges, understands and agrees that the applicant'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:** | | | | | | | **Submission Date:** | | | | | |  | | | | | | | | | | **End Date:** | |  | | | |
| **8) COUNTIES SERVED BY PROJECT:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
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| **9) AMOUNT OF FUNDING REQUESTED:** | | | | | | | | |  | | | | | | **11) PROJECT CONTACT PERSON** | | | | | | | | | | | | | |
| **10) PROJECTED EXPENDITURES** | | | | | | | | | | |  | | |  |  | Name:  Phone:  Fax:  Email: | | | | |  | | | | | | | |
| Does applicant’s projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for applicant’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 application are truthful and I warrant the applicant is in compliance with the assurances and certifications contained in **APPENDIX A: General Affirmations.** 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 applicant and I (the person signing below) am authorized to represent the applicant. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **13) AUTHORIZED REPRESENTATIVE** | | | | | | **Check if change** | | | | | | | | | | | **14) SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | | | | | | | | | | |
|  | Name:  Title:  Phone:  Fax:  Email: | | |  | | | | | | | | | | | | |  | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | **15) DATE** | | | | | | | | | | | |
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FORM B: Open Enrollment Application Checklist

Department of State Health Services

Open Enrollment Application OE No. #HHS0014260

**Each Enrollment Application Must Contain the Following Completed Items:**

|  |
| --- |
| **Documentation Required for Applicants**  **Documentation Required for Submission**  All documentation listed must be returned for a complete Application. Provide the documentation in the same sequence as outlined below by using the Item number(s) and title(s) as necessary. |
| 1. **Exhibit A – HHS Solicitation Affirmations Version 2.3**   Must be completed and signed.  **Important Note: Applications received without the signed Exhibit A will be disqualified.** |
| 1. **Exhibit B –** **HHS Uniform Terms and Conditions – Vendor – Version 3.2**   For reference |
| 1. **Exhibit C – Federal Assurances, Non-Construction**   Must be completed and signed if not doing construction or renovations |
| 1. **Exhibit D – Federal Assurances, Construction**   Must be completed and signed if doing construction or renovations |
| 1. **Exhibit E – Certification Regarding Lobbying** Must be completed and signed |
| 1. **Exhibit F – Fiscal Federal Funding Accountability and Transparency Act (FFATA) Certification**   Must be completed and signed |
| 1. **Form A - Face Page**   Must be completed and signed |
| 1. **Form B - Open Enrollment (OE) Application Checklist**   Must be completed |
| 1. **Form C - Contact Person Information Form**   Must be completed |
| 1. **Form D - Vendor Information Form**   Must be completed and signed |
| 1. **Form E- Workplan Template: FQHC Incubator- Project Workplan**   Must be completed |
| 1. **Form F - Landlord Consent for Construction on Leased Spaces.**   Must be completed as applicable for planned construction projects in leased spaces. |
| 1. **Form G - FQHC Budget Template**   Must be completed and signed |
| 1. **Notice of Insolvency or Indebtedness – Reference Section 8.7**   Provide with the Application detailed written descriptions of any insolvency, incapacity, and outstanding unpaid obligations of Applicant owed to the Internal Revenue Service (IRS) or the State of Texas, or any agency or political subdivision of the State of Texas. |
| 1. **Public Information Act Copy of Application, if applicable – Reference Section 11.1** |
| **The following appendices are not required to be submitted as part of the Application and are included for informational purposes only. Appendices will be used when submitting deliverables.** |
| 1. **Appendix A - Enrichment Activities** |
| 1. **Appendix B - Staffing List** |
| 1. **Appendix C - Capital Improvement Activities** |
| 1. **Appendix D – Progress Statement** |
| 1. **Appendix E - Budget Sheet**   Must be completed as applicable |
| 1. **Appendix F - Final Impact Report** |

FORM C: Contact Person Information Form

Department of State Health Services

Open Enrollment Application OE No. #HHS0014260

|  |  |
| --- | --- |
| Legal Business Name: |  |

This form provides information about the appropriate contacts in the Applicant’s organization in addition to those on the FACE PAGE. If any of the following information changes during the term of the Contract, please send written notification to the Contract Manager at FQHCIncubator.Contracts@dshs.texas.gov**.**

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|  | | | | | | |
| **Contact:** |  | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | |  |  |  |
| **Phone:** |  | | Ext. |  |  |  |
| **Fax:** |  | | |  |  |  |
| **E-mail:** |  | | |  |  |  |
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| **Contact:** |  | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | |  |  |  |
| **Phone:** |  | | Ext. |  |  |  |
| **Fax:** |  | | |  |  |  |
| **E-mail:** |  | | |  |  |  |
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| **Contact:** |  | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | |  |  |  |
| **Phone:** |  | | Ext. |  |  |  |
| **Fax:** |  | | |  |  |  |
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| **Contact:** |  | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | |  |  |  |
| **Phone:** |  | Ext. | |  |  |  |
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| **E-mail:** |  | | |  |  |  |
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Form D: Vendor Information Form

Department of State Health Services

Open Enrollment Application OE No. #HHS0014260

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

**Form E: Workplan Template: FQHC Incubator- Project Workplan**

Department of State Health Services

Open Enrollment Application OE No. #HHS0014260

**Organization Name:**

**Date of Application:**

**INSTRUCTIONS**: Please use this workplan template to describe in detail how you plan to use the FQHC Incubator Project funding to expand your available services or improve access to care. Please answer each question completely using the form below.

1. **Project Site Address (if there are multiple sites where project will take place, please list all of them here):**
2. **MUA/MUP Served at Project Site/s:**
3. **Please provide a brief description of the proposed project (no more than 300 words). Please include the counties which will be impacted by your proposed project** **in your description**.

1. **Funding Types**

**Instructions:** Please indicate in the space provided the amount you are requesting for each Funding Opportunity. The total of the three categories should equal $650,000 dollars. If you do not wish to receive funding for that Funding Opportunity, please include N/A in the appropriate field.

1. **Technical Assistance & Development Enrichment Amount**: $

Provide a summary of you will utilize the funding in this category. Examples of potential activities that funding can be used for including (but are not limited to) conferences, trainings, workshops, professional organization memberships, consultant costs, professional legal consultation, recruitment fees, or other costs related to assistance in management or operations of the site. Costs related to onboarding new staff members that are not equipment, such as EMR licenses, should be included in this category. Describe how these activities will expand your available services or improve access to care. As a reminder, **Signing Bonuses are not an allowable cost.** (Insert additional rows as needed).

| **Activity** | **Description** | **Date** | **Staff Member(s) & Role(s)** | **Estimated Cost** |
| --- | --- | --- | --- | --- |
| *(e.g., Conference attendance)* | *(Describe activity)* | *(Est. date)* | *(Name & Role)* |  |
| *(e.g., Workshop)* | *(Describe activity)* | *(Est. date)* | *(Name & Role)* |  |
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|  |  |  | *\*Grand Total* |  |

***\* This amount should match line A, Technical & Development Enrichment Amount***

***Please ensure this table matches your Form G: Workplan Budget Template.***

1. **Staffing Funding Amount**: $

Provide a list of the proposed staff that you will hire using FQHC Incubator Program Funding. As a reminder, FQHC Incubator funding cannot be used to pay existing staff, unless those employees are being promoted into a new position with different job duties or if they are moving from part-time to full-time work (for example, an employee currently working for 20 hours per week and increasing to 40 hours per week). Relocation expenses, sign-on bonuses and incentives are not an allowable cost. (Insert additional rows as needed). Please submit along with your application a proposed organizational chart noting the new positions listed below.

| **Position** | **Estimated Start Date** | **New or Expanded** | **Annual Salary/Fringe** | **Percent of Annual Salary/Benefits Supported by FQHC Funds** |
| --- | --- | --- | --- | --- |
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|  |  |  | *\*Grand Total* |  |

***\* This amount should match line B, Staffing Funding Amount***

***Please ensure this table matches your Form G: Workplan Budget Template.***

1. **Capital Funding Amount:**
   1. **Subcategory Totals:**
      1. **Equipment Purchase**
      2. **Construction Related Costs**
      3. **Construction**

Provide a summary of you will utilize the funding in this category. If construction is planned, please describe the scope of work and the site of work (leased space versus owned). In addition, if you intend to use leased space for construction, it is imperative that you submit **Form F: Landlord Letter of Consent**. If this funding will be used for equipment or other purchases, please describe the purchases required.

Examples of potential activities that are eligible for funding include (but are not limited to) construction costs (including labor and materials), construction related costs (such as architect fees, engineering fees, permits), and equipment (for example, medical equipment, furnishings, IT equipment). *Costs related to onboarding new staff members that are not equipment, such as EMR licenses, should be included in the Technical Assistance/Development category.*

**\*\*Please note, if your project has been awarded funding (or is awarded funding during the contract period) that requires Davis-Bacon time reporting for labor costs, labor will NOT be a reimbursable cost under this Open Enrollment.** Other construction related costs will still be reimbursable using FQHC Incubator funding.

***Please ensure this description below matches your Form G: Workplan Budget Template.***

**Description:**

1. **Sustainability Plan**

Provide a plan outlining the strategies and measures your center intends to implement to maintain financial viability and continue offering services to your target population once FQHC Incubator Funding is exhausted. If you plan to hire staff using FQHC Incubator funding, please ensure you describe clearly how staff salaries will be maintained after the contract is completed.

1. **Additional Sources of Funding**

Please list any additional sources of funding you will plan to use to complete your proposed project. **\*\*\*Please note, if your project includes construction and has been awarded funding (or is awarded funding during the contract period) that requires Davis-Bacon time reporting for labor costs, labor will NOT be a reimbursable cost under this Open Enrollment.**

|  |  |  |
| --- | --- | --- |
| Funding Source | Amount | Davis-Bacon Reporting Requirements? (Y/N) |
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1. Create a draft timeline for project completion below**.** All activities in the Draft Workplan must be completed by August 31, 2025. Please include specific timelines for all proposed activities that prove the feasibility of the planned activities in the time allotted.

**Form F: Landlord Consent for Construction on Leased Spaces**

**Department of State Health Services**

**Open Enrollment Application**

OE No. #HHS0014260

      is/are the owner(s) of the property located at      . The property is currently leased by      .       currently has/will have a lease agreement with      , for the period of       years that will expire on      .

      is/are in full agreement of the proposed improvements to the aforementioned leased property as part of the Texas Department of Health Services (DSHS).       funding opportunity, and grant permission to       to undertake proposed improvements.

      agrees to either modify the existing lease, or include in the new lease, the following restrictive terms, which will be signed by both       and      :

1. The recipient agrees not to sublease, assign, or otherwise transfer the property, or use the property for a non-FQHC Incubator Funding-related purpose(s) without the written approval from DSHS (at any time during the term of the lease/agreement, whether or not FQHC Incubator Funding support has ended).
2. The property owner will inform DSHS of any default by the recipient under the lease/agreement.
3. DSHS shall have 60 days from the date of receipt of the property owner’s notice of default in which to attempt to eliminate the default, and that the property owner will delay exercising remedies until the end of the 60-day period.
4. DSHS may intervene to ensure that the default is eliminated by the recipient or another recipient named by DSHS. The property owner shall accept payment of money or performance of any other obligation by the DSHS designee, for the recipient, as if such payment of money or performance had been made by the recipient.
5. In the event that the recipient defaults, the Contract is terminated, or the recipient vacates the property before the end of the lease term, DSHS shall have the right to designate a replacement for the recipient for the balance of the lease term, subject to approval by the property owner, which will not be withheld except for good reason.

      also acknowledge that there will be a federal interest in the property as a result of the proposed improvements and that       agrees to file a Notice of Federal Interest prior to work commencing, if required by DSHS.

|  |  |  |
| --- | --- | --- |
| Landlord/Corporation Signature: |  | |
|  |  |  |
| Typed Name: |  | |
|  |  |  |
| Title: |  | |
|  |  |  |
| Date: |  | |