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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RESPONDENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
| **1) LEGAL BUSINESS NAME :** | | | | |  | | | | | | | | | | | | | | | | | | |
| **2) MAILING Address** **Information** (include mailing address, street, city, county, state and zip code): | | | | | | | | | | | | | | | | | | | | |  |  | |
|  |  | | | | | | | | | | | | | | | | | | | | | | |
| **3) PAYEE Name and Mailing Address** (if different from above): | | | | | | | | | | | | | | | | | | | | |  |  | |
|  | |  | | | | | | | | | | | | | | | | | | | | | |
| **4) COUNTIES IN PROPOSED SERVICE AREA:** | | | | | | | | | | | | | | | | | | | | | | |
| **5) 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 Applicant's choice to use a social security number as the vendor identification number for the Grant Agreement, 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**\*** | | | | | | | |  | | Local Mental Health Authority | | | | | |
|  |  | | County | | | |  | Hospital | | | | | | | |  | | Mental Hospital | | | | | |
|  |  | | Child Care Facility | | | |  | Hospital District | | | | | | | |  | | HUB Certified | | | | | |
|  |  | | Less than 50 employees | | | | | | | | | | | | |  | | Other (Specify): | | | | | |
| **\****If incorporated, provide 10-digit charter number assigned by Secretary of State:* | | | | | | | | | | | | | | | | | | | | | | | |
| **7) BUDGET PERIOD:** | | | | | | | | | **Start Date:** | July 1, 2024 | | | | | | | | | **End Date:** | August 31, 2025 | | | |
| **8) TOTAL STATE FUNDING REQUESTED (including requested one-time funding):** | | | | | | | | | | | | **12) PRIMARY CONTACT**  Name:  Phone:  Email: | | | | | | | | | | | |
| **9) TOTAL PROPOSED PROJECT COST (including cash matching funds, and in-kind match for eligible entities):** | | | | | | | | | | | |
| 1. **ANTICIPATED TOTAL NUMBER OF UNDUPLICATED PARTICIPANTS TO BE SERVED** | | | | | | | | | | | |
| **13) FINANCIAL OFFICER** | | | | | | | | | | | |
|  | Name:  Phone:  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 the Application. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a Grant Agreement. 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. | | | | | | | | | | | | | | | | | | | | | | | |
| **14) AUTHORIZED REPRESENTATIVE** | | | | | |  | | | | | | | | **15) SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | | | | | | | | |
|  | Name:  Title:  Phone:  Email: | | |  | | | | | | | | | |  | | | | | | | | | |
| **16) DATE** | | | | | | | | | |
|  |  | | | | | | | | |

**Form a**

**Face Page-Respondent Information**

*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 Application and must be completed in its entirety.*

**FORM A: Face Page Instructions**

This form provides basic information about the Respondent and the proposed Project with the Texas Health and Human Services Commission (“**HHSC**”) Supporting Mental and Emotional Resilience in Texans (SMART) Innovation Grants, including the signature of the authorized representative. It is required to be completed. Signature affirms the facts contained in the Respondent’s Application are truthful and the Respondent is in compliance with the RFA terms and conditions. Please follow the instructions below to complete the face page form and return with the Respondent’s Application.

1. **LEGAL BUSINESS NAME** -Enter the legal name of the Respondent.
2. **MAILING ADDRESS INFORMATION** -Enter the Respondent’s complete physical 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 Grant Agreement; 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. **COUNTIES IN PROPOSED SERVICE AREA** – List the counties to be served by the proposed Project. If serving more than one (1) county, indicate the county where a majority of its Grant-funded services will be provided with an asterisk (\*).
5. **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 Grant Agreement may result in the social security number being made public via state open records requests.
6. **TYPE OF ENTITY –** The type of entity isdefined by the Secretary of State <http://www.sos.state.tx.us/corp/businessstructure.shtml>, and/or theTexas State Comptroller at <https://fmx.cpa.texas.gov/fm/pubs/payment/gen_prov/?s=tins_codes&p=ownership>, and check all other boxes that describe the entity.

* Historically Underutilized Business: A minority or women-owned business as defined by Chapter 2161 of the Texas Government Code (see <http://www.window.state.tx.us/procurement/prog/hub/>). Selection of this entity type will be used to determine eligibility of matching flexibility described in **Section 5.4, Cost Sharing or Matching Requirement**, of this RFA.
* Less than fifty (50) employees: Entities with less than fifty (50) employees. Selection of this entity type will be used to determine eligibility of matching flexibility described in **Section 5.4, Cost Sharing or Matching Requirement**, of this RFA.

1. **BUDGET PERIOD –** from the budget period for this Application, i.e. July 1, 2024, through August 31, 2025.
2. **TOTAL STATE FUNDING REQUESTED** - Enter the total amount of state funding requested from HHSC for SMART Innovation Grant Program services, including any one-time funding.
3. **TOTAL PROJECT COST** - Enter the total cost for the proposed Project including matching cash funds, matching in-kind funds for eligible entities, and amount of state funding requested from HHSC for proposed Project activities. The total funding amount requested must match the total amount requested on **Form F, State and Matching Budget Proposal**.
4. **ANTICIPATED TOTAL UNDUPLICATED PARTICIPANTS** – Enter the total number of unduplicated Participants to be served within the budget period.
5. **PRIMARY CONTACT** -Enter the name, phone, and email address of the person responsible for the proposed Project.
6. **FINANCIAL OFFICER** - Enter the name, phone, and email address of the person responsible for the financial aspects of the proposed Project.
7. **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, and email address of the person authorized to represent the Respondent.
8. **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the Respondent must sign in this blank.
9. **DATE** - Enter the date the authorized representative signed this form.