Open Enrollment No. HHS0010370
Exhibit C - Applicant Information and Disclosures
Submit as attachment to the Application

PART 1: APPLICANT BUSINESS STRUCTURE

1. Applicant's Legal Name:

2. Legal Status (check one): ☐ **For-profit** ☐ **Non-Profit** ☐ **Governmental**

3. Business Structure (check one):

☐ **Corporation (Attach copy of Certificate of Incorporation)**
State of Incorporation:
SOS Charter or Filing No.:

☐ **Limited Liability Company (LLC) (Attach copy of the Articles of Formation)**

☐ **Partnership (Attach copy of Partnership Agreement)**
☐ **Limited Liability Partnership (LLP)**
☐ **General**
If applicable, attach copy of the Signatory Agreement

☐ **Joint Venture**
☐ **Sole Proprietorship**
☐ **Other (specify):**

4. Name of Parent Entity, if applicable:

5. CPA Certified Historically Underutilized Business (HUB): ☐ **Yes** ☐ **No**
If Yes, attach current HUB Certificate issued by Comptroller of Public Accounts (CPA)

PART 2: SERVICES PROVIDED

Applicant must provide services as described and specified in the Open Enrollment.

Check All that Apply:

Inpatient Comprehensive Medical Rehabilitation Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Inpatient Hospital Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Outpatient Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Implantable Devices: ☐ **Yes** ☐ **No** ☐ **N/A**
Medical Records: ☐ **Yes** ☐ **No** ☐ **N/A**
Psychological Services: ☐ **Yes** ☐ **No** ☐ **N/A**

PART 3: RESPONDENT CONTACT INFORMATION	
PERSON AUTHORIZED TO SIGN CONTRACT **Name:** **Title:** **Mailing Address:** **Phone No.:** **E-Mail:**	**PRIMARY CONTACT FOR QUESTIONS REGARDING APPLICATION** **Name:** **Title:** **Mailing Address:** **Phone No.:** **E-Mail:**
FINANCIAL OFFICER **Name:** **Title:** **Mailing Address:** **Phone No.:** **E-Mail:**	**ACCOUNTS PAYABLE** **Name:** **Title:** **Mailing Address:** **Phone No.:** **E-Mail:**
PRIMARY CONTACT FOR CONTRACT MANAGEMENT **Name:** **Title:** **Mailing Address:** **Phone No.:** **E-Mail:**	**ALTERNATE CONTACT FOR CONTRACT MANAGEMENT** **Name:** **Title:** **Mailing Address:** **Phone No.:** **E-Mail:**

By submitting this application, the Applicant agrees to the posted solicitation and meets all the minimum requirement. ☐Yes ☐No

HHSC will send Contract related communications to the Primary Contact and Alternate, if applicable. The Contractor must maintain and monitor at least one active e-mail address for the receipt of communications regarding the Contract.

Any notice required or permitted under this contract by the Contractor to HHSC must be in writing and submitted by e-mail to this HHSC address and Point of Contact:

Health and Human Service Commission
Comprehensive Rehabilitation Services
Attn: Jessica Hissam
CRS_Contracts@hhsc.state.tx.us

Part 4: SUBCONTRACTOR INFORMATION
For each proposed subcontractor

Duplicate and attach additional pages, if necessary.

Additional Part 4 pages attached: ☐ Yes ☐ No

1. Subcontractor's Legal Name:

2. Subcontractor's Assumed Business Name (DBA), if applicable:

3. Texas County(s):
Texas County(s) for Assumed Business Name (D.B.A. or 'doing business as')
Attach Assumed Name Certificate(s) for each County

4. Physical Address (City, State, Zip):

5. Mailing Address (City, State, Zip), if different:

6. Legal Status (check one): ☐ For-profit ☐ Non-Profit ☐ Governmental

7. Business Structure (check one):
☐ **Corporation (Attach copy of Certificate of Incorporation)**
State of Incorporation:
SOS Charter or Filing No.:

☐ **Limited Liability Company (LLC) (Attach copy of the Articles of Formation**)
Partnership (Attach copy of Partnership Agreement)
☐ **Limited Liability Partnership (LLP)**
☐ **Genera**l
If applicable, attach copy of the Signatory Agreement

☐ **Joint Venture**
☐ **Sole Proprietorship**
☐ **Other (specify):**

8. Name of Parent Entity, if applicable:

9. CPA Certified Historically Underutilized Business (HUB): ☐ Yes ☐ No
If Yes, attach current HUB Certificate issued by Comptroller of Public Accounts (CPA)

Part 5: Former Employees of a State Agency

Provide information for all Respondent and Subcontractor(s), if applicable, personnel who have worked for HHSC or another Health and Human Services Agency in the past two (2) years. This will not disqualify an Applicant, but will be used to ensure no conflicts of interest.

Duplicate and attach additional pages, if necessary.
Additional Part 5 pages attached: ☐ Yes ☐ No

1. **Name of Former State Employee:**
2. **Job Title at Termination of State Employment:**
3. **Date of Termination of State Employment:**
4. **Annual Rate of Compensation at Termination:**
5. **Description of Job Responsibilities while State Employee:**
6. **If the former State Employee worked on matters relating to the Open Enrollment, describe those matters:**

Part 6: Conflicts of Interest

Describe all facts or circumstances that may give rise to a potential conflict of interest and describe all measures the respondent and its subcontractors will take to ensure that these facts or circumstances do not create an actual conflict of interest.

Duplicate and attach additional pages if necessary.
Additional Part 6 pages attached: ☐ Yes ☐ No

PART 7: LITIGATION

Disclose all pending, resolved, or completed litigation, mediation, arbitration, or other alternative dispute resolution procedure involving the Applicant within the past 36 months. Include the cause number, court, parties' names, subject matter, relief sought, amount in controversy, and final disposition or status. Litigation history may disqualify Applicant.

Provide the same information for all subcontractors.

Duplicate and attach additional pages if necessary
Additional Part 7 pages attached: ☐ Yes ☐ No

Part 8: Texas Public Information Act (PIA)

Reference Exhibit A, Affirmations and Solicitation Acceptance, Item No.3 and No.14 of the Open Enrollment.
Complete if Applicant asserts one or more parts of their Application are excepted from disclosure under the PIA.

1. **Section of Application, Exhibits or Attachments:**
2. **PIA Exception*:**
3. **Explanation of why the exception applies:**

***The most commonly asserted exception is Section 552.110 of the Texas Government Code (trade secret or commercial or financial information confidential by law).**

PART 9: LOCATION(S) FOR SERVICES

Duplicate as necessary for additional locations

Location Name:

Physical Address:

Phone No.:

Fax No.:

Inpatient Comprehensive Medical Rehabilitation Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Inpatient Hospital Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Outpatient Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Implantable Devices: ☐ **Yes** ☐ **No** ☐ **N/A**
Medical Records: ☐ **Yes** ☐ **No** ☐ **N/A**
Psychological Services: ☐ **Yes** ☐ **No** ☑ **N/A**

Location Name:

Physical Address:

Phone No.:

Fax No.:

Inpatient Comprehensive Medical Rehabilitation Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Inpatient Hospital Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Outpatient Services: ☐ **Yes** ☐ **No** ☐ **N/A**
Implantable Devices: ☐ **Yes** ☐ **No** ☐ **N/A**
Medical Records: ☐ **Yes** ☐ **No** ☐ **N/A**
Psychological Services: ☐ **Yes** ☐ **No** ☐ **N/A**