**Form a – Applicant Information Page**

## ***Application for HIV Prevention Services - Solicitation Number: HHS0013263***

*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.*

**Applicant is applying for the following activities:** *Please check all that apply*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Testing:** Focused Human Immunodeficiency Virus (HIV) / Sexually Transmitted Infection (STI) / Hepatitis C Virus (HCV) Testing in Non-Traditional Settings (Required) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **HCV Prevention:** Focused HCV Prevention and Navigation in Non-Traditional Settings (optional) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **Interventions:** Innovative Interventions: Addressing Determinants of Health (optional) | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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 (12-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 Applicant 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**\*** | | | | | | | | | | | |  | | 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:** | | | |  | | | | | | | | | | **End Date:** | |  | | | | |
| **8) COUNTIES SERVED BY PROJECT:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **9) HSDAs SERVED BY PROJECT:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **10) TOTAL AMOUNT OF FUNDING REQUESTED:** | | | | | | | | | |  | | | | **12) PROJECT CONTACT PERSON** | | | | | | | | | | | | | | | |
| **11) PROJECTED EXPENDITURES** | | | | | | | |  | | | |  | |  | Name:  Phone:  Fax:  Email: | | | | |  | | | | | | | | | |
| Does the Applicant’s projected federal expenditures exceed $750,000, or its projected state expenditures exceed $750,000, 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.* | | | | | | | | | | | | | |  |  | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | |  |  | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | **13) 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 RFA terms and conditions, including the HHS Uniform Terms and Conditions-Grant Version 3.2, and other RFA requirements. 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 Applicant and I (the person signing below) am authorized to represent the Applicant. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **14) AUTHORIZED REPRESENTATIVE** | | | | | **Check if change** | | | | | | | | | | | **15) SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | | | | | | | | | | | | |
|  | Name:  Title:  Phone:  Email: | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | |
|  |  | |  | | | | | | | | | | | | | **16) DATE** | | | | | | | | | | | | | |
|  |  | |  | | | | | | | | | | | | |  | |  | | | | | | | | | | | |

**FORM A: Applicant Information Page Instructions**

This form provides basic information about the Applicant and the proposed project with the Health and Human Services Commission (HHSC), including the signature of the authorized representative. It is the cover page of the Application and is required to be completed. Signature affirms the facts contained in the Applicant’s response are truthful and the Applicant is in compliance with the RFA terms and conditions, including the HHS Uniform Contract Terms and Conditions-Grant Version 3.2, and other RFA requirements. Please follow the instructions below to complete this form and return with the Applicant’s Application:.

1. **LEGAL BUSINESS NAME** -Enter the legal name of the Applicant.
2. **MAILING ADDRESS INFORMATION** -Enter the Applicant’s complete physical address and mailing address, city, county, state, and 9-digit zip code.
3. **PAYEE NAME AND MAILING ADDRESS** -Payee – Entity involved in a contractual relationship with Applicant to receive payment for services rendered by Applicant and to maintain the accounting records for the Grant Agreement; i.e., fiscal agent. Enter the PAYEE’s name and mailing address, including 9-digit zip code, if PAYEE is different from the Applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.
4. **UEID Number** – 12- digit Unique Entity number. This number is required if receiving **ANY** federal funds and can be obtained at: [Sam.gov](http://fedgov.dnb.com/webform)
5. **FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit). \*The Applicant acknowledges, understands and agrees the Applicant's choice to use a social security number as its 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 the type of entity as defined by the Secretary of State at <http://www.sos.state.tx.us/corp/businessstructure.shtml> and/or theTexas State Comptroller at <https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf> and check all other boxes that describe the entity.

Historically Underutilized Business**:** A minority or women-owned business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. (<http://www.window.state.tx.us/procurement/prog/hub/>)

State Agency**:** an agency of the State of Texas as defined in Texas Government Code §2056.001.ii

Institutions of Higher Education as defined by §61.003 of the Education Code.

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.

1. **PROPOSED BUDGET PERIOD** - The budget period for this Application. Budget period is defined in the RFA.
2. **COUNTIES SERVED BY PROJECT** - Enter the Region and proposed target counties to be served by the project***.***

**9) HSDAs Served by Project -** Enter the HIV Service Delivery Areas that will be served.

1. **TOTAL AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding requested from DSHS for proposed project activities (not including possible renewals).
2. **PROJECTED EXPENDITURES** -If Applicant’s projected federal expenditures exceed $750,000 or its projected state expenditures exceed $750,000 for Applicant’s current fiscal year, Applicant must arrange for a financial compliance audit (Single Audit).
3. **PROJECT CONTACT PERSON** -Enter the name, phone, fax, and email address of the person responsible for the proposed project.
4. **FINANCIAL OFFICER** - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.
5. **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and email address of the person authorized to represent the Applicant. Check the “Check if change” box if the authorized representative is different from previous submission to HHSC.
6. **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the Applicant must sign in this blank.
7. **DATE** - Enter the date the authorized representative signed this form.