**Department of State Health Services**

FORM A: FACE PAGE

*** DFHCS/HTB Program***

This form requests basic information about the respondent and project. .

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:  **6a) CONTRACTORS’ FISCAL YEAR END DATE (MM/DD):** | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | |
| **7) PROPOSED BUDGET PERIOD:** | | | | | | | | | | | **Start Date: 09/01/2022** | | |  | | | | | | | | | | **End Date: 08/31/2023** | |  | | |
| **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: | | | | |  | | | | | | | |
| **13) AUTHORIZED REPRESENTATIVE** | | | | | | **Check if change** | | | | | | | | | | |
|  | Name:  Title:  Phone:  Fax:  Email: | | |  | | | | | | | | | | | | |  | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | **14) DATE** | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | |  | |  | | | | | | | | | |

HHS0014455