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| **APPLICANT 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)** | **DUNS Number** (9-digit)**:** |  |  |  |  | **5) HHS Region:** | | |
| **6) Federal Tax ID No.** (9 digit), **State of Texas Comptroller Vendor ID No.** (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.*** | | | | | | | | |
| **7) TYPE OF ENTITY** (check all that apply): | | | | | | | | |
|  | City  County  Local Education Agency  Other (specify): | Nonprofit Organization\*  Education Service Center  Hospital | | | Local Mental Health Authority  Federally Qualified Health Center  State Controlled Institution of Higher Learning | | | |
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| **\***If incorporated, provide 10-digit charter number assigned by Secretary of State: | | | | | | | | |
| **8) BUDGET PERIOD:** | | **Start Date:** | | September 1, 2025 | | **End Date:** | | August 31, 2026 |
| **9) PROPOSED SERVICE AREA:** | | |  | | | |  | |
| **10) TOTAL ECI SERVICES FUNDING REQUESTED:** | | | | | | | | |
| The facts affirmed by me in this proposal are truthful and I warrant the Applicant 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 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. | | | | | | | | |
| **11) ELECTRONIC HEALTH RECORD SYSTEM:**  Check which applies:  Already implemented  Will be implemented by September 1, 2026 | | | | | | | | |
| **12) AUTHORIZED REPRESENTATIVE** | | | | | **13) SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | | |
| Name:  Title:  Phone:  Email: | | | | |  | | | |
| **14) DATE** | | | |

Early Childhood Intervention (ECI) Services Page 1 of 2

This form is required and provides basic information about the Applicant and the proposed project with the Texas Health and Human Services Commission (“**HHSC**”) Early Childhood Intervention (“**ECI**”). Please follow the instructions below to complete the face page form and return with the Applicant’s proposal.

1. **LEGAL BUSINESS NAME** – Enter the legal name of the Applicant.
2. **MAILING ADDRESS INFORMATION** – Enter the Applicant’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 Applicant to receive payment for services rendered by Applicant and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE’s name and mailing address if PAYEE is different from the Applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.
4. **DUNS NUMBER** – 9-digit Dun and Bradstreet Data Universal Numbering System (“**DUNS**”) number. This can be obtained at: <https://www.dnb.com/duns/get-a-duns.html>
5. **HEALTH AND HUMAN SERVICE (“HHS”) REGION** – Enter Applicant’s HHS Region(s). A map of all HHSC regions may be accessed at the following link: <https://www.hhs.texas.gov/about/contact-us/hhs-locations>
6. **FEDERAL TAX ID / STATE OF TEXAS COMPTROLLER VENDOR ID / SOCIAL SECURITY**

**NUMBER** – Enter the Federal Tax Identification Number (9-digit), the Vendor Identification Number assigned by the Texas State Comptroller (14-digit), or the Applicant’s Social Security Number. \*The Applicant acknowledges, understands and agrees 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.

1. **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>, [http://www.sos.state.tx.us/corp/nonprofit\_org.shtml,](http://www.sos.state.tx.us/corp/nonprofit_org.shtml) and/or the Texas State Comptroller at [https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-](https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf) [04/TINS\_Guide\_0409.pdf.](https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf) Check all other boxes that describe the entity.
2. **BUDGET PERIOD –** It is from September 1, 2025 through August 31, 2026.
3. **PROPOSED SERVICE AREA** - List the counties to be served by the proposed project. Note: If proposing to serve a portion of a county, list the county and then the zip codes within that county to be served.
4. **TOTAL ECI SERVICES FUNDING REQUESTED -** Enter the total amount of funding requested from HHSC for proposed project activities. The total funding amount requested must match the total amount requested on the **Proposed Counties to Be Served and Proposed Funding** (**Form D-2**).
5. **ELECTRONIC HEALTH RECORD SYSTEM –** Enter the name of the electronic health record system your organization will use for ECI client data. Check the appropriate option to indicate if the electronic health record system is already implemented or if your organization will implement the system no later than September 1, 2026.
6. **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, and email address of the person authorized to represent the Applicant.
7. **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the Applicant must sign in this blank.
8. **DATE** - Enter the date the authorized representative signed this form.

Early Childhood Intervention (ECI) Services Page 2 of 2