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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): | | | | | | | | | | | | | | | | |
|  |  | | Pregnancy Resource Center | |  | Nonprofit Organization**\*** | | |  | Maternity Home | | | | | | |
|  |  | | Adoption Assistance Agency | |  |  | | |  |  | | | | | | |
|  |  | | Other (specify): | |  |  | | |  |  | | | | | | |
|  |  | |  | |  |  | | |  |  | | | | | | |
| **\***If incorporated, provide 10-digit charter number assigned by Secretary of State: | | | | | | | | | | | | | | | | |
| **8) BUDGET PERIOD:** | | | | | | | **Start Date:** |  | | | | | **End Date:** |  | | |
| **9) TOTAL AMOUNT OF FUNDING REQUSTED:** | | | | | | | | | | | | | | | | | |
| **10) Does Applicant’s projected federal expenditures exceed $1,000,000, or its projected state expenditures exceed $1,000,000, for Applicant’s current fiscal year (excluding amount requested in line 10 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. | | | | | | | | | | | | | | | | | |
| 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) AUTHORIZED REPRESENTATIVE:**  Name:  Title:  Phone:  Email: | | | | | | | | | | | | | | | | |
| **12) AUTHORIZED REPRESENTATIVE SIGNATURE:** | | | | | | | | | | | | | | | | |
| **13) DATE:** | | | | | | | | | | | | | | | | |

This form provides basic information about the Applicant and the proposed project with the Texas Health and Human Services Commission (“**HHSC**”) Thriving Texas Families program, including the signature of the authorized representative. It is required to be completed. Signature affirms the facts contained in the Applicant’s application are truthful. 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.
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://hhs.texas.gov/about-hhs/find-us>.
6. **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 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.
7. **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>, and/or theTexas State Comptroller [at https://fmx.cpa.texas.gov/fmx/index.php](at%20https:/fmx.cpa.texas.gov/fmx/index.php). Check all other boxes that describe the entity.
8. **BUDGET PERIOD –** It is from September 1, 2025, through August 31, 2026.
9. **TOTAL AMOUNT 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 **Exhibit G, Requested Budget Summary**.
10. **TOTAL FUNDING REQUESTED** - Enter the total amount of funding requested from HHSC for Thriving Texas Families program pilot project services.
11. **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and email address of the person authorized to represent the Applicant.
12. **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the Applicant must sign in this blank.
13. **DATE** - Enter the date the authorized representative signed this form.