**FORM A - FACE PAGE**

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| **HEALTH CARE FACILITY NAME**:  **LEGAL BUSINESS NAME (if different from above):**  **MAILING ADDRESS:**  **FEDERAL TAX ID (9-DIGIT) OR TEXAS COMPTROLLER VENDOR ID (14-DIGIT):** |
| **FACILITY TYPE**:  Hospital  Nursing Facility  Freestanding Emergency Medical Care Facility  Home Health Agency  **State License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **TOTAL FUNDING REQUESTED FOR PROJECT PERIOD (BEGINNING 04/01/2026 and ENDING 02/28/2028):**  **$** |
| **Primary Contact** *(This is the Project Director who can answer questions on behalf of this Application)*  **NAME:**  **TITLE:**  **PHONE:**  **EMAIL:** |
| **Secondary Contact** *(This is a Co-Project Director who can respond on behalf of this Application)*  **NAME:**  **TITLE:**  **PHONE:**  **EMAIL:** |
| AUTHORIZED INSTITUTIONAL REPRESENTATIVE’S NAME AND TITLE (TYPED):  I certify that the statements herein are true, complete, and accurate to the best of my knowledge. I further certify that if funds are awarded, this institution accepts the obligation to comply with terms and conditions set by the Texas Health and Human Services Commission.    Authorized Institutional Representative Signature Date |