**FORM A**

**FACE PAGE**

***Application for Financial Assistance***

*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.*

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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) a. Federal Tax ID No.** (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) **or** **Social Security Number** (9 digit):  **4) b. Unique Entity ID (12-character alphanumeric ID assigned to an entity by SAM.gov)**: | | | | | | | | | | | |
| ***\*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.*** | | | | | | | | | | | |
| **5) TYPE OF ENTITY** (check all that apply): | | | | | | | | | | | |
|  |  | **City** | |  | **Nonprofit Organization\*** | |  | **Individual** | | | |
|  |  | **County** | |  | **For Profit Organization\*** | |  | **FQHC** | | | |
|  |  | **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:* | | | | | | | | | | | |
| **6) PROPOSED BUDGET PERIOD:** | | | | | | **Start Date:** | | | | **End Date:** | |
| **7) COUNTIES SERVED BY PROJECT:**  Refer to instructions for Item No. 7 | | | | | | | | | | | |
| **8) AMOUNT OF FUNDING REQUESTED:** $ | | | | | | | | | | | |
| **9) PROJECTED EXPENDITURES**: $ | | | | | | | | | **10) PROJECT CONTACT PERSON:** | | |
| Does Applicant’s projected state or federal expenditures exceed $1,000,000 for Applicant’s current fiscal year (excluding amount requested in line 9 above)? \*\*  Yes  No  *\*\*Projected expenditures should include funding for all activities including “pass through” federal funds from all state agencies and non-project related HHSC funds.* | | | | | | | | | Name:  Phone:  Fax:  E-mail: | |  |
| The facts affirmed by me in this application 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) FINANCIAL OFFICER:** | | |
| Name:  Phone:  Fax:  E-mail: | |  |
| **13) SIGNATURE OF AUTHORIZED REPRESENTATIVE:** | | |
| **12) AUTHORIZED REPRESENTATIVE:** | | | | | | | | |
| Name:  Title:  Phone:  Fax:  E-mail: | | |  | | | | | |
| **14) DATE :** | | |

**FORM A: FACE 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 assurances and certifications contained in **Exhibit A, HHS Solicitation Affirmations v.2.7** and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below to complete the face page form and return with the Applicant’s application.

1. **LEGAL BUSINESS NAME** -Enter the legal name of the Applicant.

* 1. **MAILING ADDRESS INFORMATION** -Enter the Applicant’s complete physical address and mailing address, city, county, state, and zip code.
  2. **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.
  3. **A. 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.

**B**. **UEID Number** - This number is required if receiving ANY federal funds band can be obtained at: [Home | SAM.gov](https://sam.gov/).

* 1. **TYPE OF ENTITY** -The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.
* HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the Comptroller’s Texas Procurement and Support Services or another entity.
* 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** - Enter the budget period for this application. Budget period is defined in the application.
2. **COUNTIES SERVED BY PROJECT** – By signing **Form A**, Applicant acknowledges it must provide HPP and EMTF Services for all of the counties in Texas Region 4 (TSAs F and G). Refer to **Exhibit H, Trauma Service Areas**, for the list of counties in Trauma Service Areas (TSAs) F and G.

1. **AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding requested from HHSC for each type of funding requested.
2. **PROJECTED EXPENDITURES** -If Applicant’s projected state or federal expenditures exceed $1,00,000 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 e-mail address of the person responsible for the proposed project.
4. **FINANCIAL OFFICER** - Enter the name, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.
5. **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and e-mail 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.