**Form A**

**Face Page – Applicant Information**

*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. Double click on checkboxes in this form and select “Checked” under “Default value” to check each item.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **APPLICANT 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)** | **Unique Entity Identifier (UEI) (12 characters) required:** | | | | | | | | | | | | | | | | | | | | |
| **5) Federal Tax ID No.** (9-digit), **State of Texas Comptroller Vendor ID Number** (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 Grant Agreement 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 | |  | Faith Based (Nonprofit Org) | | | | | | |  | | 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 | | | | | | |  |
|  |  |  | |  |  | | | | | | |  | | Other (specify): | |  | | | | |  |
| ***\*****If incorporated, provide 10-digit charter number assigned by Secretary of State:* | | | | | | | | | | | | |  | | | |  | | | | |
| **7) BUDGET PERIOD for YEAR ONE (FY26-FY27):** | | | | | | | | **Start Date:** | May 1, 2026 | | | | | | **End Date:** | | | August 31, 2027 | | | |
| **8) COUNTY(IES) SERVED BY PROJECT:** | | | | | | |  | | | | | | | | | | | | | | |
| **9) TOTAL AMOUNT OF FUNDING REQUESTED for YEAR ONE (FY26-FY27):** | | | | | | | | | | **10) PROGRAM:**  Service Members, Veterans, and Families (SMVF) | | | | | | | | | | | |
| **11) PROJECT CONTACT PERSON:**  **Name:**  **Title:**  **Phone:**  **Email:** | | | | | | | | | | **12) FINANCIAL OFFICER**  **Name:**  **Title:**  **Phone:**  **Email:** | | | | | | | | | | | |
| The facts affirmed by me in this proposal are truthful and I warrant the Applicant is in compliance with the RFA terms and conditions, including HHSC’s Uniform Contract Terms and Conditions, and other RFA requirements. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a Grant Agreement. 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. | | | | | | | | | | | | | | | | | | | | | |
| **13) AUTHORIZED REPRESENTATIVE** | | | | | | **Check if change** | | | | **14) SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | | | | | | | | | | |
| **Name:**  **Title:**  **Phone:**  **Email:** | | | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **15) DATE** | | | | | | | | | | | |
|  |  | | | | | | | | | | |

**Form A: Face Page – Applicant Information Instructions**

This form provides basic information about 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 RFA terms and conditions, including HHSC’s Exhibit B, HHS Uniform Terms and Conditions – Grant, Version 3.5, Effective September 2024, and other RFA requirements unless specifically noted in Exhibit I, Exceptions Form, and acknowledges that continued compliance is a condition for the award of a Grant Agreement. 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 Applicant.
2. **MAILING ADDRESS INFORMATION** -Enter Applicant’s complete physical address and mailing address, city, county, state, and 9-digit 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 Grant Agreement (i.e., fiscal agent). Enter the PAYEE’s name and mailing address, including 9-digit zip code, if PAYEE is different from Applicant. The PAYEE is the corporation, entity, or vendor who will be receiving payments.
4. **UNIQUE ENTITY IDENTIFIER (UEI)** - 12-character alpha-numeric ID. This identification is **required** if receiving **ANY** federal funds and can be obtained at: [https://sam.directory/UEI.](%20https://sam.directory/UEI%20)
5. **FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit). \*Applicant acknowledges, understands, and agrees the Applicant's choice to use a social security number as its vendor identification number for the Grant Agreement may result in the social security number being made public via State open records requests.
6. **TYPE OF ENTITY** -Check the type of entity as defined by the Secretary of State at <https://www.sos.state.tx.us/corp/businessstructure.shtml>,

and/or theTexas State Comptroller at <https://fmx.cpa.texas.gov/fm/pubs/payment/gen_prov/?s=tins_codes&p=ownership>, and check all other boxes that describe the entity.

Historically Underutilized Business: A minority- or women-owned business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. <https://comptroller.texas.gov/purchasing/vendor/hub/>

State Agency: an agency of the State of Texas as defined in Texas Government Code §2056.001.

Institutions of Higher Education as defined under Texas Education Code §61.003(8).

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, provide the 10-digit charter number assigned by the Secretary of State.

1. **BUDGET PERIOD FOR YEAR ONE** - The budget period for year one (May 1, 2026, through August 31, 2027) of this Application.
2. **COUNTY(IES) SERVED BY PROJECT** - Enter the county(ies) to be served by the Project.
3. **TOTAL AMOUNT OF FUNDING REQUESTED FOR YEAR ONE -** Enter the amount of funding requested from HHSC for proposed Project activities (not including possible renewals).
4. **PROGRAM** - HHSC completed this field. This refers to the program supported by this RFA.
5. **PROJECT CONTACT PERSON** - Enter the name, title, phone, and email address of the person responsible for the proposed Project.
6. **FINANCIAL OFFICER** - Enter the name, title, phone, and email address of the person responsible for the financial aspects of the proposed Project.
7. **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, and email address of the person authorized to represent the Applicant. Check the “Check if change” box if the authorized representative is different from a previous submission to HHSC.
8. **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the Applicant must sign in this blank.
9. **DATE** - Enter the date the authorized representative signed this form.