**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.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 if receiving federal funds:** | | | | | | | | | | | | | | | | | | | | |
| **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 | | | |  | Governmental Organization\* | | | | | |  | Federally Qualified Health Centers | | | | | | | |
|  |  | Other Political Subdivision | | | |  | VetHUB 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:* | | | | | | | | | | |  | | | | | |  | | | | |
| **7) PROPOSED BUDGET PERIOD for INITIAL YEAR:** | | | | | | | **Start Date:** | | **September 1, 2026** | | | | | | | **End Date:** | | **August 31, 2027** | | | | |
| **8) REGION & COUNTIES SERVED BY PROJECT:** | | | | | | | |  | | | | | | | | | | | | | |
| **9) TOTAL AMOUNT OF FUNDING REQUESTED:** | | | | | | | | | | **10) PROGRAM:** | | | | | | | | | | | |
| **11)** **PROJECTED EXPENDITURES**  Does Applicant’s projected federal expenditures exceed $1,000,000.00, or its projected state expenditures exceed $1,000,000.00, for Applicant’s current fiscal year (excluding amount requested in line 9 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* | | | | | | | | | |
| **12) PROJECT CONTACT PERSON:**  **Name:**  **Phone:**  **Fax:**  **Email:** | | | | | | | | | | **13) FINANCIAL OFFICER**  **Name:**  **Phone:**  **Fax:**  **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 the HHS Uniform Terms and Conditions-Grant Version 3.5, 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. | | | | | | | | | | | | | | | | | | | | | |
| **14) AUTHORIZED REPRESENTATIVE** | | | | | **Check if change** | | | | | **15) SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | | | | | | | | | |
|  | **Name:**  **Title:**  **Phone:**  **Fax:**  **ESImail:** | |  | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | |
| **16) 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. Signatory affirms the facts contained in the Applicant’s Response are truthful and the Applicant is in compliance with the RFA terms and conditions, including the HHS Uniform Terms and Conditions-Grant Version 3.5, and other RFA requirements. Please follow the instructions below to complete this form and return it with the Applicant’s Application.

1. **LEGAL BUSINESS NAME** -Enter the legal name of the Applicant.
2. **MAILING ADDRESS INFORMATION** -Enter the 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 a 9-digit zip code, if PAYEE is different from the Applicant. The PAYEE is the corporation, entity, or vendor who will be receiving payments.
4. **Unique Entity Identifier (UEI)** – Twelve-character alpha-numeric ID. This identification is required if receiving **ANY** federal funds and can be obtained at: [On-line UEI Registration and Renewal](https://sam.directory/UEI?gclid=EAIaIQobChMIgceegsyX-QIVVB-tBh25cQfOEAAYAiAAEgLw9vD_BwE)
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). \*The 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 <http://www.sos.state.tx.us/corp/businessstructure.shtml> and check all other boxes that describe the entity.

**VetHUB:** Is [Veteran Heroes United in Business](https://comptroller.texas.gov/purchasing/vendor/hub/) (VetHUB) at https://comptroller.texas.gov/purchasing/vendor/hub/). The program focuses on certification of service-disabled veterans (SDV) to facilitate their growth and development and increase VetHUB contracts and subcontracts with the State of Texas in accordance with the [Texas Government Code, Chapter 2161](https://statutes.capitol.texas.gov/?tab=1&code=GV&chapter=GV.2161&artSec=) at https://statutes.capitol.texas.gov/?tab=1&code=GV&chapter=GV.2161&artSec=.

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

Institutions of Higher Education as defined by §61.003 of the Education Code.

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. **PROPOSED BUDGET PERIOD FOR INITIAL YEAR** - The budget period for this proposal. Budget period is defined in the RFA.
2. **REGION & COUNTIES SERVED BY PROJECT** - Enter the Region and Counties to be served by the project***.***
3. **TOTAL AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding requested from HHSC for proposed project activities (not including possible renewals).
4. **PROGRAM –** Select the Program applying.
5. **PROJECTED EXPENDITURES** -If Applicant’s projected federal expenditures exceed $1,000,000.00 or its projected state expenditures exceed $1,000,000.00 for Applicant’s current fiscal year, Applicant must arrange for a financial compliance audit (Single Audit).
6. **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and email address of the person responsible for the proposed project.
7. **FINANCIAL OFFICER** - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.
8. **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and email 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.
9. **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the Applicant must sign in this blank.
10. **DATE** - Enter the date the authorized representative signed this form.