

FORM A**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 proposal 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) DUNS Number (9-digit) 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 contract, 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* | Federally Qualified Health Centers |
| ☐ County | ☐ HUB Certified | State Controlled Institution of Higher Learning |
| ☐ Other Political Subdivision | ☐ Community-Based Organization | Hospital |
| ☐ State Agency | ☐ Faith Based (Nonprofit Org) | Private |
| ☐ Indian Tribe | | |

**If incorporated, provide 10-digit charter number assigned by Secretary of State:*

7) PROPOSED BUDGET PERIOD:Start Date: **4/1/2027**End Date: **3/31/2028****8) REGION/COUNTIES SERVED BY PROJECT:****8a) IDENTIFY HIV SERVICE DELIVERY AREA(S) SERVED:****9) TOTAL AMOUNT OF FUNDING REQUESTED:****10) PROJECTED EXPENDITURES**

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.*

11) PROJECT CONTACT PERSONName:
Phone:
Fax:
Email:**12) 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 HHSC's Uniform Contract Terms and Conditions, and other RFA requirements unless specifically noted on the Applicant Information and Disclosure Form. 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.

13) AUTHORIZED REPRESENTATIVECheck if change ☐Name:
Title:
Phone:
Fax:
Email:**14) SIGNATURE OF AUTHORIZED REPRESENTATIVE****15) DATE**

FORM A

APPLICANT INFORMATION 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 proposal 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 Uniform Contract Terms and Conditions, and other RFA requirements unless specifically noted on the Applicant Information and Disclosure Form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below to complete the Applicant Information 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 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 contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address, including 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) **DUNS Number** – 9- digit Dun and Bradstreet Data Universal Numbering System (DUNS) number. This number is required if receiving ANY federal funds and can be obtained at: <http://fedgov.dnb.com/webform>
- 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 contract, 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/or Texas State Comptroller at https://fm.xcpa.texas.gov/fm/pubs/payment/gen_prov/?s=tins_codes&p=ownership and check all other boxes that describe the entity.
 - a) **Historically Underutilized Business**: A Veteran Owned Business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. (<http://www.window.state.tx.us/procurement/prog/hub/>)
 - b) **State Agency**: an agency of the State of Texas as defined in Texas Government Code §2056.001.ii
 - c) **Institutions of Higher Education** as defined by §61.003 of the Education Code.
 - d) **If a Non-Profit Corporation** provides the 10-digit charter number assigned by the Secretary of State.
- 7) **PROPOSED BUDGET PERIOD** - The budget period for this proposal. Budget period is defined in the RFA.
- 8) **REGION/COUNTIES SERVED BY PROJECT** - Enter the Region and proposed target counties to be served by the project.
- 8A) **IDENTIFY HIV SERVICE DELIVERY AREA(S) SERVED**: Enter the HIV Service Delivery Areas that will be served.
- 9) **TOTAL AMOUNT OF FUNDING REQUESTED** - Enter the amount of funding requested from HHSC for proposed project activities (not including possible renewals).
- 10) **PROJECTED EXPENDITURES** - If applicant's projected federal expenditures or its projected state expenditures exceed \$1,000,000 for applicant's current fiscal year, applicant must arrange for a financial compliance audit (Single Audit).
- 11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and email address of the person responsible for the proposed project.
- 12) **FINANCIAL OFFICER** - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.
- 13) **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.
- 14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the Applicant must sign in this blank.
- 15) **DATE** - Enter the date the authorized representative signed this form.