**Form a – Face Page**

*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) TEXAS Address** (if different from above): | | | | | | | | | | | **Time at address?** (in years and months) | | | |  | |
|  |  | | | | | | | | | | | | | | | |
| **5) Medicaid Provider Number:       OR Date Medicaid Application Submitted & TMHP Ticket #:** | | | | | | | | | | | | | | | |  |
| **6) 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.*** | | | | | | | | | | | | | | | | |
| **7) TYPE OF ENTITY** (check all that apply): | | | | | | | | | | | | | | | | |
|  |  | City | |  | Nonprofit Organization**\*** | | |  | | Individual | | | | | | |
|  |  | County | |  | For Profit Organization**\*** | | |  | | Federally Qualified Health Centers | | | | | | |
|  |  | Other Political Subdivision | |  | Hospital District | | |  | | State Controlled Institution of Higher Learning | | | | | | |
|  |  | State Agency | |  | Community-Based Organization | | |  | | Hospital | | | | | | |
|  |  | Indian Tribe | |  | Minority Organization | | |  | | Private | | | | | |  |
|  |  | Health Department | |  | University Medical Center | | |  | | Other (specify): | | |  | | |  |
| ***\*****If incorporated, provide 10-digit charter number assigned by Secretary of State:* | | | | | | |  | | | | |  | | | | |
|  | | | | | |  | | | | | | | | | | |
| **8) UEID number:** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |

**Form a – Face Page**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **9) TOTAL AMOUNT OF FUNDING REQUESTED** | | | |  | | | |
| **10)** **PROJECTED EXPENDITURES**  Does Applicant’s projected state expenditures exceed $750,000 for Applicant’s current fiscal year? \*\*  Yes  No  *\*\*Projected expenditures should include anticipated expenditures under state grants, as applicable* | | | | | **11) PROJECT CONTACT PERSON:**  **Name:**  **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 Grant Agreement 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:**  **Fax:**  **Email:** |  | | |  | | |
|  | | |
| **15) 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 Grant Agreement 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 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 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 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 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. **Texas Address (if different from above)-** Enter PAYEE’S Texas address and time in address in years and months.
5. **MEDICAID PROVIDER NUMBER OR DATE MEDICAID APPLICATION SUBMITTED –** Enter the Medicaid provider number used by the organization to bill Medicaid. If the organization does not have a Medicaid number, enter the date an application was submitted to obtain a Medicaid number and TMPH Ticket #.
6. **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.
7. **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 theTexas State Comptroller at <https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf> 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. (<http://www.window.state.tx.us/procurement/prog/hub/>)

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 or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

1. **UEID Number** - Unique Entity ID (UEI) number.
2. **TOTAL AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding requested from HHSC for proposed project activities (not including possible renewals).
3. **PROJECTED EXPENDITURES -** If Applicant’s projected state expenditures exceed $750,000 for Applicant’s current fiscal year, Applicant must arrange for a financial compliance audit (Single Audit).
4. **PROJECT CONTACT PERSON -** Enter the name, phone, fax, and email address of the person responsible for the proposed project.
5. **FINANCIAL OFFICER -** Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.
6. **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.
7. **SIGNATURE OF AUTHORIZED REPRESENTATIVE -** The person authorized to represent the Applicant must sign in this blank.
8. **DATE** - Enter the date the authorized representative signed this form.