Department of State Health Services

FORM A: FACE PAGE

FY 20 Zika Health Care Services (ZIKA-HCS)

This form requests basic information about the respondent and project. .

RESPONDENT 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 respondent acknowledges, understands and agrees that the respondent'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*	☐ Individual
☐ County	☐ For Profit Organization*	☐ 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
	☐ Faith Based (Nonprofit Org)	☐ Other (specify): _____

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

6a) CONTRACTORS' FISCAL YEAR END DATE (MM/DD):

7) PROPOSED BUDGET PERIOD: **Start Date:** **07/01/2019** **End Date:** **06/30/2020**

8) COUNTIES SERVED BY PROJECT:

9) AMOUNT OF FUNDING REQUESTED:

10) PROJECTED EXPENDITURES

Does respondent's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for respondent'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.*

11) PROJECT CONTACT PERSON

Name:
Phone:
Fax:
Email:

12) FINANCIAL OFFICER

Name:
Phone:
Fax:
Email:

13) AUTHORIZED REPRESENTATIVE **Check if change** ☐

Name:
Title:
Phone:
Fax:
Email:

14) DATE