

Department of State Health Services

FORM A FACE PAGE

CONTRACTOR 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 <input type="checkbox"/>	
3) PAYEE Name and Mailing Address, including 9-digit zip code (if different from above): Check if address change <input type="checkbox"/>	
4) Unique Entity ID (12-character alphanumeric ID assigned to an entity by SAM.gov) required if receiving federal funds: LHACK1UL6NR3	
5) Federal Tax ID No. (9-digit), State of Texas Comptroller Vendor ID Number (14-digit) or Social Security Number (9-digit): <i>*The Contractor acknowledges, understands and agrees that the Contractor'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.</i>	
6) TYPE OF ENTITY (check all that apply):	
<input type="checkbox"/> City	<input type="checkbox"/> Nonprofit Organization*
<input type="checkbox"/> County	<input type="checkbox"/> For Profit Organization*
<input type="checkbox"/> Other Political Subdivision	<input type="checkbox"/> HUB Certified
<input type="checkbox"/> State Agency	<input type="checkbox"/> Community-Based Organization
<input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Minority Organization
	<input type="checkbox"/> Faith Based (Nonprofit Org)
	<input type="checkbox"/> Individual
	<input type="checkbox"/> Federally Qualified Health Centers
	<input type="checkbox"/> State Controlled Institution of Higher Learning
	<input type="checkbox"/> Hospital
	<input type="checkbox"/> Private
	<input type="checkbox"/> Other (specify): _____
<i>*If incorporated, provide 10-digit charter number assigned by Secretary of State:</i>	
7) PROPOSED BUDGET PERIOD:	Start Date: 09/01/2024 End Date: 08/31/2025
8) COUNTIES SERVED BY PROJECT:	
9) AMOUNT OF FUNDING REQUESTED: \$125,000.00	11) PROJECT CONTACT PERSON
10) PROJECTED EXPENDITURES Does Contractor's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for Contractor's current fiscal year (excluding amount requested in line 9 above)? ** Yes <input type="checkbox"/> No <input type="checkbox"/> <i>**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.</i>	Name: Phone: Fax: Email:
	12) FINANCIAL OFFICER
13 NAME OF AUTHORIZED DOCUSIGN SIGNATORY Check if change <input type="checkbox"/> Name: Title: Phone: Fax: Email:	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE
	15) DATE

FORM A-1 CONTACT PERSON INFORMATION

Legal Business

Name of Contractor: _____

This form provides information about the appropriate contacts in the Contractor's organization in addition to those on FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Management Unit.

Contact: _____ Title: _____ Phone: _____ Fax: _____ Email: _____ Program Manager/PI (required)	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
Contact: _____ Title: _____ Phone: _____ Fax: _____ Email: _____ Accounting/Invoice Preparation (required)	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
Contact: _____ Title: _____ Phone: _____ Fax: _____ Email: _____ Alternate Accounting/Invoice Preparation (required)	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
Contact: _____ Title: _____ Phone: _____ Fax: _____ Email: _____ Other (Specify Title):	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____
Contact: _____ Title: _____ Phone: _____ Fax: _____ Email: _____ Other (Specify Title):	Mailing Address (incl. street, city, county, state, & zip): _____ _____ _____ _____