Department of State Health Services (DSHS)

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 renewal and shall be completed in its entirety. Signature of face page certifies to all DSHS and program assurances listed in this renewal document.

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
- ☐ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith Based (Nonprofit Org)
- ☐ Individual
- ☐ Federally Qualified Health Centers
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

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

7) PROPOSED BUDGET PERIOD: **Start Date:** 09/01/2017 **End Date:** 08/31/2018

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:

The facts affirmed by me in this proposal are truthful and I warrant the respondent is in compliance with the assurances and certifications contained in **APPENDIX B: DSHS Assurances and Certifications**. 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 respondent and I (the person signing below) am authorized to represent the respondent.

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

Name:
Title:
Phone:
Fax:
Email:

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

15) DATE

FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the DSHS, including the signature of the authorized representative. It is the cover page of the renewal application and is required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original DSHS contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

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 the Texas 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.

7) **PROPOSED BUDGET PERIOD** - Budget period for this renewal application has been entered for you.

8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project. Include all counties in the HIV Administrative Services Area.

9) **AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding per the allocation given from DSHS for proposed project activities (not including possible renewals). This amount must match column (1) row J from the BUDGET SUMMARY template(s) used for cost reimbursement budgets.

10) **PROJECTED EXPENDITURES** - If applicant's projected federal expenditures exceed $500,000 or its projected state expenditures exceed $500,000 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 DSHS.

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.

FORM B: CONTACT PERSON INFORMATION

Legal Name of Applicant: _____

This form provides information about the appropriate program contacts in the applicant's organization. If any of the following information changes during the term of the contract, please notify the ***Contract Manager and the HIV Care Services Group.***

Executive Director:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Project Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Financial Reporting Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Data Reporting Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Clinical Services Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Board Chairperson:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Emergency Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		

FORM C: HIV/SS PERFORMANCE MEASURE Guidelines

With this renewal application complete a separate proposed Table 1 for State Services and another for State-R funding. A total of two Table 1's must be completed per service provider by HSDA.

Performance measures related to access and quality of care are included in the Ryan White contract and must be incorporated in updates to your comprehensive services plan either in the goals and objectives section or attached as an addendum to the plan. **Each AA is required to implement their comprehensive plans; it is required to implement the measures and report your progress in your quarterly report.**

REQUIRED PERFORMANCE MEASURES

Administrative Measures

1. The contractor will have subcontracted 100% of all State Services (SS) and State-Rebate (State-R) funds as applicable to the contract, no later than thirty (30) days after the first day of the contract year (i.e., by 9/30/17).

2. The contractor will submit an 8-categorical budget for each subcontractor receiving SS and State-R funds no later than 30 days after the first day of the contract year (i.e., by 9/30/17).

3. Contractor shall implement a quality management (QM) system according to the Contractor's established QM Plan.

4. The contractor will submit complete quarterly reports according to the reporting due dates listed in the contract.

5. No less than ninety-five (95%) of SS and S-R funds will be expended by the end of the respective contract year.

6. Contractor shall provide clinical, programmatic and financial monitoring of subcontractors for all funded service categories according to contractor's established internal policies, procedures, and schedules.

7. Contractor shall distribute all funds according to the service priorities and allocations established in its approved Comprehensive HIV Services Plan, and make reallocations in accordance to DSHS policy.

State Services Measures

8. Contractor shall ensure that no more than ten percent of the State SS and State-R allocation is expended by service providers (subcontractors) for administrative costs.

9. Contractor shall use these funds to provide at least one SS to (Insert #) unduplicated clients during Project Year (FY) 2017/18 (09/01/17 – 08/31/18). Proposed objectives related to the # of persons and units to be provided must be reflected on Table 1: Services Priorities, Allocations, and Objectives.

10. Contractor shall use these funds to provide at least one State-R service to

(Insert #__) unduplicated clients during Project Year (FY) 2017/18 (09/01/17 – 08/31/18). Proposed objectives related to the # of persons and units to be provided must be reflected on Table 1: Services Priorities, Allocations, and Objectives.

11. Contractor will submit a Subcontractor Data Sheet no later than 30 days after the first day of the contract year (09/01/17). The subcontractor budget must be attached (see administrative measure #2 above).

12. Contractor must enter complete and correct SS and State-R contracts in ARIES no later than 30 days after the first day of the contract year (i.e., by 09/30/17). The naming convention for each ARIES contract included in the statement of work must be followed.

13. Contractor shall increase enrollment in Health Plans of eligible persons in the HSDA's by no less than 10% for persons that fall between 100% and 200% of the federal poverty level (FPL). This measure is a minimum and the AA can require enrollment and FPL levels locally.

14. Contractor shall monitor the delivery of HIV services against the Estimated Units of Services and Unduplicated Clients to be served in the Initial ARIES contracts.

ADAP Enrollment Worker (AEW) Measures:

15. The Administrative Agency will provide aggregate data by HSDA regarding the AEW performance measures quarterly.

16. ≥ 95% of new enrollee ADAP applications are accepted by the THMP upon initial submission.

17. ≥95% of new enrollee applications are submitted within 10 business days of initial contact with the client.

18. 100% of applications rejected or held by the THMP because of missing or inaccurate documentation are followed-up with the applicant within 2 business days of notice from the THMP.

19. ≥95% of ADAP eligibility Re-certifications and Attestations are completed on or before the lapse of ADAP program benefits.

20. All efforts made on behalf of the applicant are documented in the appropriate file (e.g. medical record, client primary record) within 1 business day of occurrence.