

**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 <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) 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):	
<i>*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.</i>	
6) TYPE OF ENTITY (check all that apply):	
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Other Political Subdivision <input type="checkbox"/> State Agency <input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Nonprofit Organization* <input type="checkbox"/> For Profit Organization* <input type="checkbox"/> HUB Certified <input type="checkbox"/> Community-Based Organization <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: 04/01/2016      End Date: 03/31/2017
8) COUNTIES SERVED BY PROJECT:	
9) AMOUNT OF FUNDING REQUESTED:	11) PROJECT CONTACT PERSON
10) PROJECTED EXPENDITURES	Name: Phone: Fax: Email:
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 <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>	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 <b>APPENDIX B: DSHS Assurances and Certifications</b> . 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	14) SIGNATURE OF AUTHORIZED REPRESENTATIVE
Name: Title: Phone: Fax: Email:	
Check if change <input type="checkbox"/>	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://fmxcpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS\\_Guide\\_0409.pdf](https://fmxcpa.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: XXX-HIV-RW

*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**.*

<p><b>Executive Director:</b> _____</p> <p><b>Title:</b> _____</p> <p><b>Phone:</b> _____ <b>Ext.</b> _____</p> <p><b>Fax:</b> _____</p> <p><b>E-mail:</b> _____</p>	<p><b>Mailing Address (incl. street, city, county, state, &amp; zip):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Project Contact:</b> _____</p> <p><b>Title:</b> _____</p> <p><b>Phone:</b> _____ <b>Ext.</b> _____</p> <p><b>Fax:</b> _____</p> <p><b>E-mail:</b> _____</p>	<p><b>Mailing Address (incl. street, city, county, state, &amp; zip):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Financial Reporting Contact:</b> _____</p> <p><b>Title:</b> _____</p> <p><b>Phone:</b> _____ <b>Ext.</b> _____</p> <p><b>Fax:</b> _____</p> <p><b>E-mail:</b> _____</p>	<p><b>Mailing Address (incl. street, city, county, state, &amp; zip):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Data Reporting Contact:</b> _____</p> <p><b>Title:</b> _____</p> <p><b>Phone:</b> _____ <b>Ext.</b> _____</p> <p><b>Fax:</b> _____</p> <p><b>E-mail:</b> _____</p>	<p><b>Mailing Address (incl. street, city, county, state, &amp; zip):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Clinical Services Contact:</b> _____</p> <p><b>Title:</b> _____</p> <p><b>Phone:</b> _____ <b>Ext.</b> _____</p> <p><b>Fax:</b> _____</p> <p><b>E-mail:</b> _____</p>	<p><b>Mailing Address (incl. street, city, county, state, &amp; zip):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Board Chairperson:</b> _____</p> <p><b>Title:</b> _____</p> <p><b>Phone:</b> _____ <b>Ext.</b> _____</p> <p><b>Fax:</b> _____</p> <p><b>E-mail:</b> _____</p>	<p><b>Mailing Address (incl. street, city, county, state, &amp; zip):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Emergency Contact:</b> _____</p> <p><b>Title:</b> _____</p> <p><b>Phone:</b> _____ <b>Ext.</b> _____</p> <p><b>Fax:</b> _____</p> <p><b>E-mail:</b> _____</p>	<p><b>Mailing Address (incl. street, city, county, state, &amp; zip):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>

## **FORM C: HIV/RW PERFORMANCE MEASURE Guidelines**

Contracts will include the negotiated Table 1 and the total number of unduplicated clients that will be served as the performance measures. A separate Table 1 will be completed for Ryan White and RW Supplemental per HSDA.

Performance measures related to access and quality of care 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 Ryan White Service Delivery and/or State Services funds as applicable to the contract, no later than thirty (30) days after the first day of the contract year (i.e., by 5/1/17).
2. The contractor will submit provider budgets for Ryan White Service Delivery and RW Supplemental no later than 30 days after the first day of the contract year (i.e., by 5/1/17).
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 this contract.
5. No less than ninety-five (95%) of Ryan White and RW Supplemental funds will be expended by the end of the respective contract year.
6. Contractor shall provide clinical, programmatic and financial monitoring of subcontractors 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.

## Ryan White Service Delivery and RW Supplemental Measures

8. Contractor shall ensure that no more than ten percent of the Ryan White Service Delivery and RW Supplemental allocation is expended by service providers (subcontractors) for administrative costs.
9. Contractor shall use these funds to provide at least one **RWSD** to **(Insert #)** unduplicated clients during Project Year (FY) 2017 (04/1/17 – 03/31/18). 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 **RW Supplemental** service to **(Insert #)** unduplicated clients during Project Year (FY) 2017 (04/1/17 – 9/29/17). Objectives related to the # of persons and units to be provided must be reflected on Table 1: Services Priorities, Allocations, and Objectives.
11. Complete a proposed Table 1 for each HSDA for RWSD and a proposed Table 1 for each HSDA for RW Supplemental. Contractor must enter complete and correct RW and RW Supplemental contracts in ARIES no later than 30 days after the first day of the contract year (i.e., by 5/1/17). The naming convention for each ARIES contract included in the statement of work must be followed.
12. 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.
13. 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.

## **FORM D: HIV/RW-SS SERVICE SYSTEM OBJECTIVE GUIDELINES**

### **Contractor:**

Applicant must write service system improvements for administrative functions and identify proposed target levels. The objectives and levels of performance will be negotiated through the contract development process. Objectives must be reported for the entire HIV Administrative Service Area (HASA).

### Requirements:

1. Identify three (3) performance objectives from your Comprehensive HIV Services Plan that you plan to focus on for FY 2017-2018.

## **FORM D: HIV/RW-SS SERVICE SYSTEM OBJECTIVES**

### **Contractor:**

*Applicant agrees that system objective(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements (see RWAA Service System Objective Guidelines) associated with the services proposed in this renewal application.*

1. For performance objectives identified on Form D, question 1, describe how the AA intends to achieve each objective. Descriptions must include specific, detailed and measurable benchmark steps to achieving each objective as well as descriptions of who (e.g. AA staff, community partners) is responsible for completing each step.