TEXAS
Department of
State Health Services

Approved

Commissioners Court

MAY 26 2015

FY 2016/17 Request for Adult Potentially Preventable Hospitalizations (PPH) Initiative Funds

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Contract documents are due to DSHS on or before Friday, May 15, 2015 by 5:00 p.m. @ via email to elma.medina@dshs.state.tx.us with a cc: mike.gilliam@dshs.state.tx.us

Please contact your contract manager at (512) 776-2181 for assistance in completing the FY16/17 EXEC/PPH contract documents.

TEXAS
Department of
State Health Services

FY 2016/17 Adult Potentially Preventable Hospitalizations (PPH) Initiative

FORM A - FACE PAGE

RESPONDENT INFORMATION

1) LEGAL NAME:

2) MAILING Address Information (include mailing address, street, city, county, state and zip code):

3) PAYEE Mailing Address (if different from above):

4) Federal Tax ID No. (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or if an individual, **Social Security Number** (9 digit) :
*The vendor acknowledges, understands and agrees that the vendor'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.

5) TYPE OF ENTITY (check all that apply):

- ☐ City
- ☐ Regions/Counties/LHD
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith-based Organization
- ☐ Individual
- ☐ FQHC
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

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

6) COUNTIES OR REGION SERVED BY PROJECT:
See attached County/Region list.

7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: Phone: Fax: E-mail:	☐ **EXEC/PPH** $_____

The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications attached in **FORM E,** and will provide services in accordance with **25 Texas Administrative Code, §§37.51-37.65.** 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.

8) AUTHORIZED REPRESENTATIVE	**9) DATE**
Name: Title: Phone: Fax: E-mail:	

GENERAL INSTRUCTIONS FOR THE FACE PAGE

This form provides basic information about the applicant and the proposed project with the Department of State Health Services (DSHS), including the name of the authorized representative. It is the cover page of the proposal and is required to be completed. **DSHS Assurances and Certifications** and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below to complete the face page form and return with the applicant's proposal.

1) **LEGAL NAME** - Enter the legal name of the applicant.

2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and zip code.

3) **PAYEE 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 if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID/SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit). *The vendor acknowledges, understands and agrees that the vendor'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.

5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

   HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the Texas Building and Procurement Commission or another entity.

   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.

6) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties or region to be served by the project.

7) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.

8) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and e-mail 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.

9) **DATE** - Enter the date this form is completed.

TEXAS Department of State Health Services

FY 2016/17 Adult Potentially Preventable Hospitalizations (PPH) Initiative

Program Contact Information

Contract Term: September 1, 2015 through August 31, 2017

Legal Name of Applicant: [redacted]

This form provides information about appropriate program contacts in the applicant's organization. If any of the contact information changes during the term of the contract, please send written notification to the Regional and Local Health Service & Compliance Branch, Mail Code 1990, P.O. Box 149347, Austin, TX 78714 or email to ***LocalPHTeam@dshs.state.tx.us*** *.*

Director

Contact: _____ **Mailing Address (street, city, county, state, & zip):**
Title: _____ _____
Phone: _____ _____
Fax: _____ _____
E-mail: _____ _____

Financial Manager

Contact: _____ **Mailing Address (street, city, county, state, & zip):**
Title: _____ _____
Phone: _____ _____
Fax: _____ _____
E-mail: _____ _____

Contract Coordinator

Contact: _____ **Mailing Address (street, city, county, state, & zip):**
Title: _____ _____
Phone: _____ _____
Fax: _____ _____
E-mail: _____ _____

Additional Staff

Contact: _____ **Mailing Address (street, city, county, state, & zip):**
Title: _____ _____
Phone: _____ _____
Fax: _____ _____
E-mail: _____ _____

Additional Staff

Contact: _____ **Mailing Address (street, city, county, state, & zip):**
Title: _____ _____
Phone: _____ _____
Fax: _____ _____
E-mail: _____ _____

NOTICE

Refer to 2nd Excel file via email for DSHS Categorical Budget Forms

General Instructions for Completing Budget Forms
DSHS Costs Only Budgeted on Detail Category Pages

(Examples and instructions for completing the Budget Category Detail Templates are in a separate Excel file located under Templates for Cost Reimbursement Budgets located at : http://www.dshs.state.tx.us/grants/forms.shtm

* Enter the legal name of your organization in the space provided for "Legal Name of Respondent" on Form I -Budget Summary; doing so will populate the budget category detail templates with your organizations name.

* Complete each budget category detail template. Instructions for completing each budget category detail template are in a separate document. If a primary budget category detail template does not accommodate all items in your budget, use the respective supplemental budget template at the end of this workbook. The total of each supplemental category detail budget template will automatically populate to the last line of the respective primary budget category template.

* After you have completed each budget category detail form, go to Form I-Budget Summary and input other sources of funding manually (if any) in Columns 3 - 6 for each budget category.

* Refer to the table below the budget template table to verify that the amounts distributed ("Distribution Total") in each budget category equals the "Budget Total" for each respective category. Next, verify that the overall total of all distributions ("Distribution Totals") equals the Budget Total.

* Enter the total amount of "Program Income" anticipated for this program in row "K" under the "Total Budget" column (1). The total program income budgeted will be automatically allocated to each funding source based on the percentage of funding of the total budget. Information on program income is available in the DSHS Contractors Financial Procedures Manual located at the following web site: http://www.dshs.state.tx.us/contracts/