FORM A: FACE PAGE – Application for Financial Assistance Tuberculosis Prevention

This form requests basic information about the respondent and project, including the signature of the authorized representative. The face page is the cover page of the proposal and must be completed in its entirety.

RESPONDENT INFORMATION

1) LEGAL BUSINESS NAME: Fort Bend County Clinical Health Services

2) MAILING Address Information (include mailing address, street, city, county, state and zip code): **Check if address change** ☐

Fort Bend County Clinical Health Services
4520 Reading Road, Suite A
Rosenberg, Texas 77471

3) PAYEE Name and Mailing Address (if different from above): **Check if address change** ☐

Fort Bend County Auditor
301 Jackson Street, Suite 533
Richmond, Texas 77469

4) Federal Tax ID No. (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or **Social Security Number** (9 digit) : 746001969

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.

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

	City		
X	County	For Profit Organization*	FQHC
	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:*

6) PROPOSED BUDGET PERIOD: **Start Date:** **01/01/2012** **End Date:** **12/31/2012**

7) COUNTIES SERVED BY PROJECT:
Fort Bend County

8) AMOUNT OF FUNDING REQUESTED: **$102,645.00**

9) PROJECTED EXPENDITURES

Does respondent's projected state or federal expenditures exceed $500,000 for respondent's current fiscal year (excluding amount requested in line 8 above)? **

Yes X No ☐

***Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related DSHS funds.*

10) PROJECT CONTACT PERSON

Name: **Nancy Drake, RN**
Phone: **281-238-3548**
Fax: **281-342-7371**
E-mail: **drakenan@co.fort-bend.tx.us**

11) FINANCIAL OFFICER

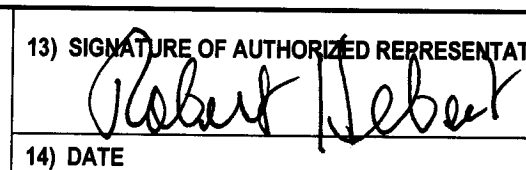
Name: **Robert E. Sturdivant**
Phone: **281-344-3760**
Fax: **281-341-3774**
E-mail: **sturdrob@co.fort-bend.tx.us**

The facts affirmed by me in this proposal are truthful and I warrant that the respondent is in compliance with the assurances and certifications contained in **APPENDIX A: DSHS Assurances and Certifications**. I understand that 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.

12) AUTHORIZED REPRESENTATIVE **Check if change**

Name: **Robert E. Hebert County Judge**
Title:
Phone: **281-341-8608**
Fax: **281-341-8609**
E-mail: **hebertb@co.fort-bend.tx.us**

13) SIGNATURE OF AUTHORIZED REPRESENTATIVE



14) DATE

August 4, 2011