TEXAS Department of State Health Services

Division for Regional and Local Health Services

FY 2013 Local Public Health Services

FORM A - FACE PAGE

RESPONDENT INFORMATION

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

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

4520 Reading Road, Ste. 200
Rosenberg, TX 77471

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

Fort Bend County Auditor
301 Jackson Street
Richmond, TX 77469

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) : 746001969

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. Fort Bend County

7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: Nancy Drake R.N. Phone: 281-238-3548 Fax: 281-342-7371 E-mail: Nancy.drake@co.fort-bend.tx.us	X☐ LPHS $28,091.61

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) SIGNATURE OF AUTHORIZED REPRESENTATIVE
Name: Robert Hebert Title: County Judge Phone: 281-341-8608 Fax: 281-341-8609 E-mail: werleann@co.fort-bend.tx.us	Robert Hebert 10) DATE June 13, 2012

***Form A – FACE PAGE must be scanned & emailed with signature to** localphteam@dshs.state.tx.us*
OR fax to (512) 834-4519