

**FORM A: FACE PAGE****CONTRACTOR INFORMATION**

- 1) **LEGAL BUSINESS NAME:** Fort Bend County Clinical Health Services
- 2) **MAILING Address Information** (include mailing address, street, city, county, state and 9-digit zip code): ☐ Check if address change
Fort Bend County Clinical Health Services, 4520 Reading Rd, Ste A-200, Rosenberg TX 77471
- 3) **PAYEE Name and Mailing Address, including 9-digit zip code** (if different from above): ☐ Check if address change
Fort Bend County, 301 Jackson Street, Suite 533, Richmond, TX 77469
- 4) **DUNS Number (9-digit) required if receiving federal funds:** N/A
- 5) **Federal Tax ID No. (9-digit), State of Texas Comptroller Vendor ID Number (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.*

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

- | | | |
|--|---|--|
| <input type="checkbox"/> City | <input type="checkbox"/> Nonprofit Organization* | <input type="checkbox"/> Individual |
| <input checked="" type="checkbox"/> County | <input type="checkbox"/> For Profit Organization* | <input type="checkbox"/> Federally Qualified Health Centers |
| <input type="checkbox"/> Other Political Subdivision | <input type="checkbox"/> HUB Certified | <input type="checkbox"/> State Controlled Institution of Higher Learning |
| <input type="checkbox"/> State Agency | <input type="checkbox"/> Community-Based Organization | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Indian Tribe | <input type="checkbox"/> Minority Organization | <input type="checkbox"/> Private |
| | <input type="checkbox"/> Faith Based (Nonprofit Org) | <input type="checkbox"/> Other (specify): _____ |

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

7) **PROPOSED BUDGET PERIOD:** Start Date: **December 1, 2013** End Date: **August 31, 2014**

8) COUNTIES SERVED BY PROJECT:

Fort Bend County

9) **AMOUNT OF FUNDING REQUESTED:** \$10,000

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: Ed Sturdivant
Phone: 281-314-3760
Fax: 281-341-3374
Email: Ed.Sturdivant@fortbendcountytexas.gov

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: Robert Hebert
Title: County Judge
Phone: 281-341-8608
Fax: 281-341-6809
Email: Ann.Werlein@fortbendcountytexas.gov

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE**15) DATE**

October 14, 2013