**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.**

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| **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** | | |  | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3) PAYEE Name and Mailing Address, including 9-digit zip code** (if different from above): | | | | | | | | | | | | | | | | | | | | | | | | **Check if address change** | | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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): | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| **\*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): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | City | | | |  | | Nonprofit Organization**\*** | | | | | | | | | |  | | Individual | | | | | | | |
|  |  | | County | | | |  | | For Profit Organization**\*** | | | | | | | | | |  | | Federally Qualified Health Centers | | | | | | | |
|  |  | | 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: | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | |
| **7) PROPOSED BUDGET PERIOD:** | | | | | | | | | | | **Start Date:** | | | 4/1/2025 | | | | | | | | | **End Date:** | | 03/31/2026 | | | |
| **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  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.* | | | | | | | | | | | | | | |
|
| **12) FINANCIAL OFFICER** | | | | | | | | | | | | | |
|  | Name:  Phone:  Fax:  Email: | | | |  | | | | | | | | |
| The facts affirmed by me in this proposal are truthful and I warrant the respondent is following the assurances and certifications contained in **APPENDIX B: DSHS Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and 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** | | | | | | | | | | | **14) SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | | | | | | | | | | |
|  | Name:  Title:  Phone:  Fax:  Email: | | |  | | | | | | | | | | | | |  | | | | | | | | | | | |
| **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 renewal application's cover page and must 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 theTexas State Comptroller at <https://fmx.cpa.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.

1. **PROPOSED BUDGET PERIOD** - Budget period for this renewal application has been entered for you.
2. **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project. Include all counties in the HIV Administrative Services Area.
3. **AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding per the allocation given from DSHS for proposed project activities (not including renewals). This amount must match column (1) row J from the BUDGET SUMMARY template(s) used for cost reimbursement budgets.
4. **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).
5. **PROJECT CONTACT PERSON** -Enter the name, phone, fax, and email address of the person responsible for the proposed project.
6. **FINANCIAL OFFICER** - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.
7. **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.
8. **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant must sign in this blank.
9. **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.**

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| **Executive Director:** | |  | | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | | | |  |  |  |
| **Phone:** |  | | | | Ext. |  |  |  |
| **Fax:** |  | | | | |  |  |  |
| **E-mail:** |  | | | | |  |  |  |
|  | | | | | | | | |
| **Project Contact:** | |  | | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | | | |  |  |  |
| **Phone:** |  | | | Ext. | |  |  |  |
| **Fax:** |  | | | | |  |  |  |
| **E-mail:** |  | | | | |  |  |  |
|  | | | | | | | | |
| **Financial Reporting Contact:** | |  | | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | | | |  |  |  |
| **Phone:** |  | | Ext. | | |  |  |  |
| **Fax:** |  | | | | |  |  |  |
| **E-mail:** |  | | | | |  |  |  |
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| **Data Reporting Contact:** | |  | | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | | | |  |  |  |
| **Phone:** |  | | Ext. | | |  |  |  |
| **Fax:** |  | | | | |  |  |  |
| **E-mail:** |  | | | | |  |  |  |
|  | | | | | | | | |
| **Clinical Services Contact**: | |  | | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | | | |  |  |  |
| **Phone:** |  | | Ext. | | |  |  |  |
| **Fax:** |  | | | | |  |  |  |
| **E-mail:** |  | | | | |  |  |  |
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| **Board Chairperson:** | |  | | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | | | |  |  |  |
| **Phone:** |  | | | | Ext. |  |  |  |
| **Fax:** |  | | | | |  |  |  |
| **E-mail:** |  | | | | |  |  |  |
|  | | | | | | | | |
| **Emergency Contact**: | |  | | | |  | **Mailing Address (incl. street, city, county, state, & zip):** | |
| **Title:** |  | | | | |  |  |  |
| **Phone:** |  | | Ext. | | |  |  |  |
| **Fax:** |  | | | | |  |  |  |
| **E-mail:** |  | | | | |  |  |  |
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**FORM C: HIV/RW PERFORMANCE MEASURE Guidelines**

Complete a separate Table 1 for Ryan White per HSDA (HIV Service Delivery Area) to serve as proposed allocations and performance measures for contract negotiations.

Incorporate performance measures related to access and quality of care in updates to your comprehensive services plan either in the goals and objectives section or attached as an addendum to the plan. **Each AA (Administrative Agency) is required to implement the measures and report the progress in the semi-annual and annual reports from the comprehensive plan.**

**REQUIRED PERFORMANCE MEASURES**

**Administrative Measures**

1. The contractor shall have subcontracted 100% of all Ryan White Service Delivery funds no later than thirty (30) days after the first day of the contract year (i.e., by 5/1/25), or 30 days after an executed amendment, if applicable.
2. The contractor shall submit an electronic copy of each subrecipient contract, budget, and subcontractor data sheet for Ryan White Part B, no later than forty-five calendar days after the first day of the contract year (i.e., by 5/15/25), or forty-five calendar days after an executed amendment, as applicable. Each amended subrecipient budget must have a Subcontractor Data Sheet and revised TCT contract screen.
3. The contractor shall implement a quality management (QM) program according to the Contractor’s established QM Plan.
4. The contractor shall submit complete quarterly data reports and semi-annual and annual narrative reports according to the Reporting Due Dates listed in this contract.
5. Expend no less than ninety-five (95%) of Ryan White Part B funds by the end of the respective contract year.
6. The contractor shall conduct clinical, programmatic, and financial monitoring of subrecipients according to DSHS requirements and the Contractor’s established internal policies, procedures, and schedules.
7. The 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 with DSHS policy.
8. The contractor shall request a program income allocation plan for all service providers that are 340-B entities under the DSHS grant ID for Ryan White Part B. Submit these plans to DSHS Fiscal Support and Oversite and Care Services Group no later than April 1, 2025. The current template and instructions are located at: [Tech Help | FSO | Texas DSHS](https://www.dshs.texas.gov/grant-applications-funding/fiscal-monitoring/tech-help-fso) and more information can be found here: [https://www.dshs.state.tx.us/fiscal-monitoring/docs/Program-Income-Allocation-Spending-Plan-](https://www.dshs.state.tx.us/fiscal-monitoring/docs/Program-Income-Allocation-Spending-Plan-2020.xlsx) 2020.xlsx
9. The contractor shall submit a plan to engage and solicit community input as required in DSHS [policy 241.004 Administrative Agency Requirements for Community Input.](https://www.dshs.texas.gov/hivstd/policy/policies/241-004) This plan shall be included and submitted with this annual Administrative Agency renewal application.
10. The contractor shall direct all service providers to update program Payor of Last Resort policies to support the THMP TIAP-PLUS insurance purchasing program. HIA funding should be made available to support medical visit copayments, which TIAP-PLUS is not authorized to pay. If a client is eligible for enrollment in a health insurance plan, agencies should refer the client to TIAP-PLUS. THMP staff will determine the client’s THMP and health insurance plan eligibility before plan enrollment. The contractor shall also direct service providers to assist with health insurance plan enrollment using certified assistors, brokers, or other local resources.

**Ryan White Part B Service Delivery Measures**

1. The contractor shall ensure that no more than ten (10) percent of the Ryan White Service Delivery allocation is expended by service providers (subcontractors) for administrative costs.
2. The contractor shall use these funds to provide at least one **RWSD (Ryan White Service Delivery)** to (Insert #) unduplicated clients during Project Year (FY) 2026 (04/01/25–03/31/26). Reflect objectives related to the # of persons and units to be provided on Table 1 and Subcontractor Data Sheets.
3. The contractor must enter complete and correct RW initial contracts in the Uniform Reporting System (URS) Take Charge Texas (TCT) no later than thirty calendar days after the first day of the contract year (i.e., by 5/1/25), or thirty calendar days from an executed amendment, if applicable. Follow the naming convention for each URS contract included in the statement of work. Note: Create service delivery contracts in TCT for 340 B program income for entities under the DSHS grant ID for Ryan White Part B.
4. The contractor shall monitor the delivery of HIV services against the Estimated Units of Services (UOS) and Unduplicated Clients (UDC) to be served in the Initial URS contracts.

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

**Contractor Name:**

*The contractor agrees that system objective(s) will be used to assess, in part, the effectiveness in providing the services described. Address all the requirements associated with the services proposed in this renewal application****.***

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).

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

1. Identify three (3) performance objectives from your Comprehensive HIV Services Plan to focus on for FY 2025-2026.
2. Describe how the AA intends to achieve each objective.
   1. Description must include:
      1. Detailed and measurable benchmark steps to achieving each objective (may include in table).
      2. Descriptions of who (e.g., AA staff position, community partners) is responsible for completing each step (include relevant experience of organization or staff).
      3. Include AA staff person or position responsible for tracking progress and reporting outcomes.