Attachment I

System Agency Solicitation No. HHS0001365

TEXAS
Health and Human Services

Dr. Courtney N. Phillips, Executive Commissioner

Request for Applications ("RFA")
for the
Title V Maternal and Child Health Fee-for-Service Program
RFA No. HHS0001365

Date of Release: Friday, February 8, 2019

Responses Due: Monday, March 4, 2019 by 2:00 p.m. Central Time

Commodity Code:
948-48 Health Care Services (Not otherwise Classified)

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ARTICLE I. EXECUTIVE SUMMARY, DEFINITIONS, AND AUTHORITY

1.1 EXECUTIVE SUMMARY

The State of Texas, by and through the Texas Health and Human Service Commission ("HHSC") Medical and Social Services Division announces the availability of funding for Child Health and Dental ("CHD") and Prenatal Medical and Dental ("PMD") services under the Title V Maternal and Child Health Fee-for-Service Program (the "Program"). Qualified Grantees will deliver prenatal, child health, and dental services to eligible Clients in accordance with the specifications in this request for applications ("RFA" or "Solicitation") and in compliance with applicable federal and state laws, regulations, and policies.

The Title V Maternal and Child Health Fee-for-Service Program is funded by the Title V Maternal and Child Health Services ("MCH") Block Grant ("Title V" or "Title V Block Grant"). Eligible Clients must have a gross family income at or below 185% of the adopted Federal Poverty Level ("FPL"), must be Texas residents, and must not be eligible for Medicaid, Children's Health Insurance Program ("CHIP"), or other programs/benefits providing the same services. A client receiving CHIP benefits may become eligible for Title V when CHIP benefits are exhausted.

Child health services include preventive and primary child health care for children and adolescents from birth through the 21st year. Additionally, case management services are provided to children from birth to one year through Title V Children and Pregnant Women ("Title V CPW") case management. Services include screening and eligibility determination, direct clinical services, laboratory services, and appropriate referrals as necessary.

Child dental services include preventive and primary dental care for children and adolescents from birth through the 21st year. Services include screening and eligibility determination, direct dental services, and appropriate referrals as necessary.

Prenatal medical services include direct health care services to pregnant women of all ages. Services includes screening and eligibility determination, direct clinical services, laboratory services, Title V CPW case management, and appropriate referrals as necessary. Providers may provide prenatal care and bill Title V up to 60 days for prenatal care services and a maximum of two case management contacts (for contractors that are approved to provide case management) for women who are in the process of applying for and enrolling in the CHIP Perinatal Program. Providers are required to inform, encourage, and assist pregnant women in the CHIP Perinatal Program application process.

Prenatal dental services include dental services to pregnant women of all ages up to three months post-partum. A maximum of two clinical prenatal care visits will be allowed for women who are in the process of applying for and enrolling in the CHIP Perinatal Program. Services include screening and eligibility determination, dental services, and appropriate referrals as necessary.

To be considered for funding for one or more of the services under the Program, Respondents must execute **Exhibit A: Affirmations and Solicitation Acceptance**, of this Solicitation and provide all other required information and documentation set forth in this Solicitation.

1.2 DEFINITIONS

Refer to **Exhibit B: HHSC Uniform Terms and Conditions – Grant, Version 2.16** for additional definitions. Additionally, as used in this Solicitation, unless the context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

"Addendum" means a written clarification or revision to this Solicitation issued by the System Agency.

"Apparent Grantee" means an organization that has been selected to receive a grant award through response to this RFA but has not yet executed a grant agreement or contract. May also be referred to as "Apparent Grant Recipient."

"Client" means a member of the target population to be served by the Respondent's organization. For the purposes of this grant, a client is an eligible individual receiving CHD or PMD services.

"DSHS" means the Department of State Health Services established under Chapter 12 of the Texas Health and Safety Code or its designee.

"eGrants" the electronic marketplace where State of Texas grant opportunities are posted.

"Health and Human Services Commission" OR "HHSC" means the administrative agency established under Chapter 531, Texas Government Code or its designee.

"HUB" means historically underutilized business, as defined by Section 2161.001(2) of the Texas Government Code.

"Key Personnel" means a Respondent organization's Project contact, fiscal contact, and executive director and/or any other key stakeholders in the Proposed Project.

"Project" means the work and activities for which grant funding is awarded and information is provided as part of the response to this Solicitation. During the open application period and before selection of grant recipients are made, the Project will be known as the Proposed Project.

"Respondent" means the entity responding to this Solicitation. May also be referred to as "Applicant."

"Solicitation" means this RFA including any exhibits, forms and Addenda.

"State" means the State of Texas and its instrumentalities, including HHSC, the System Agency and any other state agency, its officers, employees, or authorized agents.

"Successful Respondent" means an organization that receives a grant award as a result of this RFA. May also be referred to as "Grantee, ""Awarded Applicant," "Subrecipient" or "Grant Recipient."

"System Agency" means System Agency as defined in **Exhibit B: HHSC Uniform Terms and Conditions – Grant, Version 2.16**, Section 1.2.

1.3 AUTHORITY

The System Agency is requesting applications under Title V of the Social Security Act (1935).

Within Texas, the Title V operates within a framework articulated by the Texas Legislature and the Health and Human Services Commission.

ARTICLE II. SCOPE OF GRANT AWARD

2.1 PROGRAM BACKGROUND

Through Title V of the Social Security Act of 1935, the federal government pledged to support state efforts to ensure the health of all mothers and children. In 1981, the Maternal and Child Health Services ("MCH") Block Grant was created under Title V to further improve the health of mothers, women of childbearing age, infants, children, adolescents, and children with special health care needs ("CSHCN"). In Texas, the MCH Title V Block Grant is administered by HHSC. Title V funding is used to address the following areas, including, but not limited to:

A. Significantly reducing infant mortality;

B. Providing comprehensive care for women before, during, and after pregnancy and childbirth;

C. Providing preventive and primary care services for infants, children, and adolescents; and

D. Providing comprehensive care for CSHCN.

Systems of care are designed to be family-centered, comprehensive, coordinated and community-based.

2.2 GRANT AWARD AND TERM

2.2.1 Available Funding

The total amount of state and federal funding available for the Program under this RFA for state fiscal year ("FY") 2020 (which is defined as the twelve-month period beginning September 1, 2019 through August 31, 2020) and state FY 2021 (which is defined as the twelve-month period beginning September 1, 2020 and ending August 31, 2021) is **$16,812,316.** It is HHSC's intention to make multiple awards. Funds shall be allocated in accordance with **Table 1** below.

Table 1: Allocation of Program Funds

Fiscal Year	Type of Service	Anticipated Funding Available
2020	Child Health and Child Dental Services	$7,005,000
	Prenatal Medical and Prenatal Dental Services	$1,401,158
2021	Child Health and Child Dental Services	$7,005,000
	Prenatal Medical and Prenatal Dental Services	$1,401,158

Funds are awarded for the purpose specifically defined in this RFA and must not be used for any other purpose. Funds must not be used to supplant local, state, or federal funds.

Contracts awarded under this RFA and any anticipated contract renewals are contingent upon the continued availability of funding.

HHSC reserves the right to re-allocate grant funds to prevent underutilization in the event HHSC determines, in its sole discretion, that a Grantee cannot reasonably utilize all funds awarded.

This RFA is not limited to this source of funding if other sources become available for this Program.

HHSC reserves the right to alter, amend, or withdraw this RFA at any time prior to the execution of a Contract if funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or agencies, amendment of the appropriations act, health and human services agency consolidations, or any other disruption of current appropriations.

2.2.2 Reimbursement for Title V Maternal and Child Health Services

Grantees are reimbursed for allowable CHD and PMD services on a fee-for-service basis using established reimbursement rates available online at http://www.dshs.state.tx.us/chscontracts/default.shtm. Grantees must bill HHSC on a monthly basis for services delivered using invoice templates provided annually by HHSC. Reimbursement requests are due to HHSC on the last day of the month following the month of service delivery. Rates are subject to change at HHSC's sole discretion.

Specific requirements related to the provision of Title V services are found in the Title V Policies and Procedures Manual for the Title V Maternal and Child Health Fee-for-Service for Child Health, Dental and Prenatal (2017) ("the Program Manual") available at http://www.dshs.texas.gov/mch/fee/pandp.shtm.

Title V rate worksheets including reimbursement codes, service and procedure descriptors and reimbursement rates can be found at http://www.dshs.state.tx.us/chscontracts/default.shtm.

2.2.3 Grant Term

The initial grant funding period for this grant will be twenty-four (24) months. It is anticipated that the grant funding period will begin September 1, 2019 through August 31, 2021. The grant may be extended for three (3) additional two (2) year periods at HHSC's sole discretion. Continued funding of a contract is contingent upon the availability of funds and the satisfactory performance of the contractor during the prior budget period. Funding may vary and is subject to change each renewal period. Reimbursement will only be made for those allowable expenses that occur within the term of the grant. No pre-award spending will be allowed.

2.3 Eligible Applicants

In order to be awarded a contract as a result of this RFA a Respondent must meet the following eligibility conditions:

A. Respondent must be a governmental entity (health department, hospital district, university medical center, and other state or local agency), a federally qualified health center, or a nonprofit entity.
B. Respondent must be a Medicaid provider or provide evidence with its Application that a Medicaid application has been submitted to obtain a Texas Provider Identifier ("TPI") number. The Medicaid number provided must be for the organization itself, and not for individual providers associated with the organization.
C. Respondent must be established as an appropriate legal entity under state statutes and must have the authority and be in good standing to do business in Texas and to conduct the activities described in this RFA.

D. Respondent must have a Texas address. A post office box may be used when the RFA is submitted, but the Respondent must conduct business at a physical location in Texas prior to the date that the contract is awarded.

E. Respondent must not be debarred, suspended, or otherwise excluded or ineligible for participation in federal or state assistance programs.

F. Respondent's staff members, including the executive director, must not serve as voting members on Respondent's governing board.

G. In compliance with the Texas Comptroller of Public Accounts' ("CPA") Statewide Procurement Division rules, a name search will be conducted using the websites listed in this section prior to the development of a contract. A Respondent is not considered eligible to contract with HHSC, regardless of the funding source, if a name match is found on any of the following lists:

1. The General Services Administration's ("GSA") System for Award Management ("SAM") for parties excluded from receiving federal contracts, certain subcontracts and from certain types of federal financial and non-financial assistance and benefits. https://sam.gov/SAM/;

2. The Office of Inspector General ("OIG") List of Excluded Individuals/Entities Search: https://oig.hhsc.state.tx.us/Exclusions/search.aspx; and

3. The CPA Debarment List: https://comptroller.texas.gov/purchasing/programs/vendor-performance-tracking/debarred-vendors.php?_ga=1.174613857.2106378599.1474983658. If this web link does not open, copy and paste to your internet browser window.

Respondents must meet these requirements throughout the entirety of the application process and, if chosen for grant award, must continue to meet them through the entirety of the grant funding period. HHSC expressly reserves the right to review and analyze the documentation submitted and to request additional documentation, and determine the Respondent's eligibility to compete for the contract award.

2.4 PROGRAM REQUIREMENTS

Grantees will provide CHD and/or PMD services to eligible Clients in System Agency approved counties in accordance with applicable laws, rules, policies, and the Program Manual. CHD and PMD services may include but are not limited to screening and eligibility determination, direct clinical and/or dental services, laboratory services, Title V CPW case management and appropriate referrals, as necessary.

2.5 SCOPE OF WORK

In developing applications in response to this RFA, Respondents will be required to complete attached Forms A through S to address the following:

Form A: Face Page. Basic information about the Respondent and the proposed project including the signature of the authorized representative.

Form B: Administrative Information. Information regarding identification and contract history of the Respondent, executive management, project management, governing board members, and/or principal officers.

Form C-1: Governmental Entity - Authorized Officials. Identification of and contact information for officials authorized to enter into a contract on behalf of a governmental entity.

Form C-2: Nonprofit or For-Profit Entity - Board of Directors and Principal Officers. Identification of and contact information for members of the Board of Directors and other principal officers of nonprofit or for-profit entities.

Form D: Respondent Background. Narrative description of the Respondent's organization, staff, systems, and oversight structure.

Form E: Assessment Narrative. Narrative description addressing each of the assessment items associated with the services proposed in this RFA.

Form F: Respondent Site Readiness. Checklist of physical facility, technology and accessibility requirements.

Form G: Title V Clinic Sites. Title V clinic site information including name, address, contact information, services provided, and days and hours of operation.

Form H: Title V Fee-for-Service Program Assurances. Statement of assurances regarding Title V service delivery.

Form I: Child Support Certification. Certification regarding the Texas Family Code, Section 231.006, provisions relating to child support obligors.

Form J: Title V Child Health & Child Dental Services, Texas Counties and Regions. List of counties in which Respondent will provide child health and/or child dental services.

Form K: Contact Person Information - Title V Child Health Services. Contact information for the executive director, medical director and other key staff of Respondents providing child health services

Form L: Contact Person Information - Title V Child Dental Services. Contact information for the executive director, dental director and other key staff of Respondents providing child dental services.

Form M: Service Delivery Plan for Child Health & Child Dental Services. Description of Respondent's plan for delivery of child health and/or child dental services to the eligible population in the proposed service area and timelines for accomplishments.

Form N: Title V Prenatal Medical & Prenatal Dental Services - Texas Counties and Regions. List of counties in which Respondent will provide prenatal medical and/or prenatal dental services.

Form O: Contact Person Information - Title V Prenatal Medical Services. Contact information for the executive director, medical director and other key staff of Respondents providing prenatal medical services.

Form P: Contact Person Information - Title V Prenatal Dental Services. Contact information for the executive director, dental director and other key staff of Respondents providing prenatal dental services.

Form Q: Service Delivery Plan for Prenatal Medical & Prenatal Dental Services. Description of Respondent's plan for delivery of prenatal medical and/or prenatal dental services to the eligible population in the proposed service area and timelines for accomplishments.

Form R-1: Title V Child Health & Child Dental Ceiling Request and Performance Measures. Identifies the number of child health and child dental Clients to be served and Project funds required to deliver Title V services.

Form R-2: Title V Prenatal Medical & Prenatal Dental Ceiling Request and Performance Measures. Identifies the number of prenatal medical and prenatal dental Clients to be served and Project funds required to deliver Title V services.

Form S: Title V Subcontractor Information. Identify subcontractor(s) that provide direct service to HHSC Title V Clients.

To meet the mission and objectives of the Program, a Respondent must:

A. Maintain an established referral relationship with a qualified provider for each approved service Respondent does not provide.
B. Identify, define, and prioritize specific interventions addressing the specific health care needs of the community.
C. Ensure ongoing community involvement in the planning, implementation, and evaluation of the program.
D. Ensure involvement of representatives of the cultural, racial, ethnic, gender, economic, and linguistic diversities within the community.
E. Provide adequate automation systems to ensure direct communication with HHSC.
F. Show evidence of new hire and annual periodic orientation of all staff to Title V concepts, and revisions as applicable to their job descriptions.
G. Provide documentation that all staff who perform child health exams following the Texas Health Steps periodicity schedule, have completed the online Texas Health Steps module entitled "Texas Health Steps: Overview" within ninety (90) days of contract execution. As staff attrition

occurs, new staff performing child health exams are required to complete the module within ninety (90) days of hire. The Texas Health Steps module is located at: https://www.txhealthsteps.com/profession/general-ce. Free continuing education ("CE") credits are available for the completion of this and other Texas Health Steps modules.

H. Notify HHSC of any issues, concerns, or questions regarding Title V services.

I. Establish and implement eligibility, clinical, reporting, and billing systems for Title V.

J. Work with other local, state, and federal entities in the community to develop a network of complementary services.

K. Screen all participants for Program eligibility with an approved screening process and refer to other programs/funding sources as appropriate. Failure to adequately screen is deemed as unsatisfactory performance and may result in defunding.

L. Screen for identification of mental health, substance abuse, and family violence issues.

M. Develop and maintain a referral system with effective follow-up.

N. Develop a working relationship with other programs to ease the referral process for Clients.

O. Comply with eligibility, clinical, reporting, and billing mandates outlined in the Program Manual.

P. Work in collaboration with HHSC to improve performance deemed unsatisfactory.

Q. Develop and implement a quality management process in accordance with Section I, Chapter 7 - Quality Management of the Program Manual.

R. Send laboratory tests to the lab of the provider's choice, except newborn screening tests, mandated by law, must be sent to the Austin DSHS laboratory. Grantees are required to follow the guidelines in Section II, Chapter 7 "DSHS Laboratory Services" of the Program Manual.

S. If providing child dental services, meet the following Healthy People 2020 Oral Health goals:

1. OH-1: Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth.
   a. OH-1.1. Reduce the proportion of young children aged three (3) to five (5) years with dental caries experience in their primary teeth.
   b. OH-1.2. Reduce the proportion of children aged six (6) to nine (9) years with dental caries experience in their primary or permanent teeth.
   c. OH-1.3. Reduce the proportion of adolescents aged thirteen (13) to fifteen (15) years with dental caries experience in their permanent teeth.
2. OH-2: Reduce the proportion of children and adolescents with untreated dental decay.
   a. OH-2.1. Reduce the proportion of young children aged three (3) to five (5) years with untreated dental decay in their primary teeth.
   b. OH-2.2. Reduce the proportion of children aged six (6) to nine (9) years with untreated dental decay in their primary or permanent teeth.
   c. OH-2.3. Reduce the proportion of adolescents aged thirteen (13) to fifteen (15) years with untreated dental decay in their permanent teeth.
3. OH-7: Increase the proportion of children, adolescents, and adults who used the oral health system in the past twelve (12) months.

T. If providing prenatal medical services, comply with the following:

1. Ensure prenatal medical services are provided concurrently with the CHIP Perinatal Program. A maximum of two (2) clinical prenatal care visits will be allowed for women who are in the process of applying for and enrolling in the CHIP Perinatal Program. Grantee must inform, encourage, and assist pregnant women in the CHIP Perinatal Program application process.
2. Enroll as CHIP Perinatal providers or have a mechanism in place for prenatal care benefits to be coordinated with existing CHIP Perinatal providers in the areas served.

U. If providing child health or prenatal medical services, ensure Title V CPW case management services are available to assist certain high-risk Clients to access medical, social, educational, and other types of critical services. A Title V Client is eligible for these services if he/she is:
1. A woman of any age with a high-risk pregnancy;
2. A child, birth through one (1) year of age, with a health condition and/or health risk;
3. In need of services to prevent illness(es) or medical condition(s), to maintain function, or slow further deterioration; and
4. Desires case management.

In order to provide and bill for Title V CPW services, providers must be Medicaid CPW providers, must have registered and completed the DSHS CPW training, and must have a CPW case manager on staff. Information about the required training is available online at http://www.dshs.texas.gov/caseman/default.shtm.

V. If providing prenatal dental care, meet the following Healthy People 2020 Oral Health Goals:
1. OH-3.1: Reduce the proportion of adults aged thirty-five (35) to forty-four (44) years with untreated dental decay.
2. OH-7: Increase the proportion of children, adolescents, and adults who used the oral health system in the past twelve (12) months.
3. OH-10: Increase the proportion of local health departments and federally qualified health centers ("FQHCs") that have an oral health component.
4. OH-14: Increase the proportion of adults who receive preventive interventions in dental offices.
    a. OH-14.1. Increase the proportion of adults who received information from a dentist or dental hygienist focusing on reducing tobacco use or smoking cessation in the past year.
    b. OH-14.2. Increase the proportion of adults who received an oral and pharyngeal cancer screening from a dentist or dental hygienist in the past year.
    c. OH-14.3. Increase the proportion of adults who are tested or referred for glycemic control from a dentist or dental hygienist in the past year.

W. In addition, Grantee must encourage prenatal oral health for the health of the baby. This can be supported and realized through preventive and primary dental care of the pregnant woman with the following goals:
1. Decrease the transmission of decay causing bacteria from the mother to the infant.
2. Decrease the inflammatory mediators associated with gum (periodontal) disease (periodontitis) that are the same inflammatory mediators found in diabetes, cardiovascular

disease, and arthritis and impact the ability to effectively treat these conditions during pregnancy and post-partum.

3. Reduce the bacterial load within the pregnant woman's mouth.
4. Restore the pregnant woman's mouth to function to allow adequate nutritional intake to support healthy development of the fetus and infant.

Title V Prenatal Dental, the CHIP Perinatal Program, and Medicaid for prenatal services will run concurrently. During the first dental visit, Grantee will ensure that the woman is or will receive prenatal services via Medicaid, CHIP Perinatal, or Title V. Post-partum dental services may continue up to three months following the delivery.

X. Comply with the most recent version of the Program Manual available online at: http://www.dshs.texas.gov/mch/fee/pandp.shtm .

Y. Conduct Program activities in accordance with federal and state laws prohibiting discrimination. Guidance for adhering to nondiscrimination requirements can be found on the HHSC Civil Rights Office website at: https://hhs.texas.gov/about-hhs/your-rights/civil-rights-office .

Upon request, a Grantee must provide the HHSC Civil Rights Office with copies of all the Grantee's civil rights policies and procedures. Grantees must notify HHSC's Civil Rights Office of any civil rights complaints received relating to performance under the Contract no more than ten (10) calendar days after receipt of the complaint. Notice must be directed to:

Civil Rights Office
Health and Human Services Commission
701 W. 51st Street, Mail Code W206
Austin, TX 78751
Phone Toll Free (888) 388-6332
Phone: (512) 438-4313
TTY Toll Free (877) 432-7232
Fax: (512) 438-5885
HHSCivilRightsOffice@hhsc.state.tx.us

A Grantee must ensure that its policies do not have the effect of excluding or limiting the participation of persons in the Grantee's programs, benefits or activities on the basis of national origin and must take reasonable steps to provide services and information both orally and in writing. Grantees must communicate in languages other than English in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

Grantees must comply with Executive Order 13279 and its implementing regulations at 7 CFR Part 16 or 45 CFR Part 87, which provide that any organization that participates in programs funded by direct financial assistance from the U.S. Deptartment of Agriculture or U.S. Deptartment of Health and Human Services must not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

Z. Grantees are required to conduct project activities in accordance with the most recent DSHS Standards for Public Health Clinic Services and the Program Manual located at: http://www.dshs.state.tx.us/mch/fee/pandp.shtm . Grantees may obtain a copy of the most recent

DSHS Standards for Public Health Clinic Services which is posted on the DSHS website at: http://www.dshs.state.tx.us/qmb/dshsstndrds4clinicservs.pdf.

HHSC reserves the right to modify the scope of work of the Contract and to incorporate special provisions into contracts awarded under this RFA.

2.6 PERFORMANCE MEASURES

HHSC will monitor the performance of contracts awarded under this RFA. Monitoring will be conducted for fiscal, programmatic, and administrative components of the Contract. All services and deliverables under the Contract shall be provided at an acceptable quality level and in a manner consistent with acceptable industry standard, custom, and practice.

Performance will be measured using data obtained from **Form R-1: Title V Child Health & Child Dental Ceiling Request and Performance Measures** and **Form R-2: Title V Prenatal Medical & Prenatal Dental Ceiling Request and Performance Measures**, as applicable. Specifically, performance will be measured based on the following:

A. The unduplicated number of Clients served by Respondent during the applicable budget period.
B. The average cost per Client for each proposed service during the applicable budget period.
C. The outcomes of providing services and supports as part of the proposed project. Respondents will be required to demonstrate the effectiveness of clinical services provided by conducting pre- and post-assessments with Clients and ensuring satisfaction questionnaires are completed by Clients who received services as part of the Program.

2.7 PROHIBITIONS

MCH Title V Block Grant funds may not be used for cash payments to intended recipients of health services; for in-patient services except as permitted by 42 U.S. Code § 704, as amended; for purchase or improvement of land, buildings, or major medical equipment; for satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds; or for payment for any item or service (other than an emergency item or service) furnished by or provided at the medical direction or prescription of an individual or entity that is excluded from participation in certain federal programs (*see* 42 U.S. Code § 704).

In addition, grant funds may not be used to support the following services, activities, and costs:

A. Inherently religious activities such as prayer, worship, religious instruction, or proselytization;
B. Lobbying;
C. Any portion of the salary of, or any other compensation for, an elected or appointed government official;
D. Vehicles or equipment for government agencies that are for general agency use and/or do not have a clear nexus to terrorism prevention, interdiction, and disruption (i.e., mobile data terminals, body cameras, in-car video systems, or radar units, etc. for officers assigned to routine patrol);
E. Weapons, ammunition, tracked armored vehicles, weaponized vehicles or explosives (exceptions may be granted when explosives are used for bomb squad training);
F. Admission fees or tickets to any amusement park, recreational activity or sporting event;

G. Promotional gifts;
H. Food, meals, beverages, or other refreshments, except for eligible per diem associated with grant-related travel or where pre-approved for working events;
I. Membership dues for individuals;
J. Any expense or service that is readily available at no cost to the grant project;
K. Any use of grant funds to replace (supplant) funds that have been budgeted for the same purpose through non-grant sources;
L. Fundraising;
M. Statewide projects;
N. Any other prohibition imposed by federal, state, or local law; and
O. The acquisition or construction of facilities.

2.8 STANDARDS

Grantees must comply with the requirements applicable to this funding source cited in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR Part 200); the Uniform Grant Management Standards ("UGMS"), and all statutes, requirements, and guidelines applicable to this funding.

2.9 DATA USE AGREEMENT

By entering into a Contract, or purchase order with the System Agency as a result of this Solicitation, Respondent agrees to be bound by the terms of the **Texas HHS System Data Use Agreement (DUA)** attached as **Exhibit C-1**.

Respondents must submit attachment 2 to the Texas HHS System Data Use Agreement, **Security and Privacy Inquiry (SPI),** with their proposal which is attached as **EXHIBIT C-2.**

2.10 NO GUARANTEE OF VOLUME, USAGE, OR COMPENSATION

The System Agency makes no guarantee of volume, usage, or total compensation to be paid to any Respondent under any awarded Grant resulting from this Solicitation, any awarded Grant is subject to appropriations and the continuing availability of funds.

The System Agency reserves the right to cancel, make partial award, or decline to award a Grant under this Solicitation at any time at its sole discretion.

There should be no expectation of additional or continued funding on the part of the Grant Recipient. Any additional funding or future funding may require submission of an application through a subsequent RFA.

2.11 TERMS AND CONDITIONS

The terms and conditions outlined throughout this RFA govern the RFA and any resulting contract. Any Contract awarded under this RFA include the following exhibits, found at the end of this document:

A. **EXHIBIT A: Affirmations and Solicitation Acceptance**
B. **EXHIBIT B: HHSC Uniform Terms and Conditions – Grant Version 2.16**
C. **EXHIBIT C-1: Texas HHS System Data Use Agreement**
D. **EXHIBIT C-2: Security and Privacy Inquiry (SPI) Form**
E. **EXHIBIT I: HHSC SPECIAL CONDITIONS**

DSHS reserves the right, at its sole discretion, to change, modify, add or remove terms and conditions governing the resulting Contract.

The remainder of this page is intentionally left blank.

ARTICLE III. ADMINISTRATIVE INFORMATION

3.1 SCHEDULE OF EVENTS

EVENT	DATE/TIME
Solicitation Release Date	Friday, February 8, 2019
Respondent Conference (optional)	Thursday, February 14, 2019
Deadline for Submitting Questions	Friday, February 15, 2019 at 2:00PM Central Time
Answers to Questions Posted	Tuesday, February 19, 2019
Deadline for submission of Solicitation Responses [NOTE: Responses must be RECEIVED by HHSC by the deadline.]	Monday, March 4, 2019 at 2:00PM Central Time
Anticipated Notice of Award	Friday, May 31, 2019
Anticipated Contract Start Date	Sunday, September 1, 2019

Note: These dates are a tentative schedule of events. The System Agency reserves the right to modify these dates at any time upon notice posted to the eGrants, located at https://egrants.gov.texas.gov/Default.aspx or the Electronic State Business Daily ("ESBD") website, located at http://www.txsmartbuy.com/sp. Any dates listed after the Solicitation Response deadline will occur at the discretion of the System Agency and may occur earlier or later than scheduled without notification on the eGrants or on the **ESBD website.**

3.2 CHANGES, AMENDMENT OR MODIFICATION TO SOLICITATION

The System Agency reserves the right to change, amend or modify any provision of this Solicitation, or to withdraw this Solicitation, at any time prior to award, if it is in the best interest of the System Agency and will post such on the eGrants and ESBD website. It is the responsibility of Respondent to periodically check the eGrants and on the ESBD website to ensure full compliance with the requirements of this Solicitation.

3.3 IRREGULARITIES

Any irregularities or lack of clarity in this Solicitation should be brought to the attention of the point of contact listed in **Section 3.4.1** as soon as possible so corrective Addenda may be furnished to prospective Respondents.

3.4 INQUIRIES

3.4.1 Point of Contact

All requests, questions or other communication about this Solicitation shall be made in writing to the System Agency's point of contact addressed to the person listed below. All communications between

Respondents and other System Agency staff members concerning the Solicitation are strictly prohibited, unless noted elsewhere in this RFA. **Failure to comply with these requirements may result in disqualification of Respondent's Solicitation Response.**

Name: Colette Norman, CTCD, CTCM
Title: Purchaser
Address: 1100 West 49th Street, Austin, TX
Phone: 512-406-2614
Email: Sarita.paton@hhsc.state.tx.us on behalf of Colette Norman.

3.4.2 Prohibited Communications

All communications between Respondents and other System Agency staff members concerning the Solicitation may not be relied upon and Respondents should send all questions or other communications to the point of contact. This restriction does not preclude discussions between affected parties for the purposes of conducting business unrelated to this Solicitation. **Failure to comply with these requirements may result in disqualification of Respondent's Solicitation Response.**

3.4.3 Questions

The System Agency will allow written questions and requests for clarification of this Solicitation. Questions must be submitted in writing and sent by U.S. First class mail or email to the point of contact listed in **Section 3.4.1** above. Respondents' names will be removed from questions in any responses released. Questions shall be submitted in the following format. Submissions that deviate from this format may not be accepted:

A. Identifying Solicitation number;
B. Section Number;
C. Paragraph Number;
D. Page Number;
E. Text of passage being questioned; and
F. Question.

Note: Questions or other written requests for clarification must be received by the point of contact by the deadline set forth in Section 3.4.1 above. Please provide entity name, address, phone number; fax number, e-mail address, and name of contact person when submitting questions.

3.4.4 Clarification Request Made by Respondent

Respondents must notify the point of contact of any ambiguity, conflict, discrepancy, exclusionary specifications, omission or other error in the Solicitation in the manner and by the deadline for submitting questions.

3.4.5 Responses

Responses to questions or other written requests for clarification will be posted on the eGrants and ESBD website. The System Agency reserves the right to amend answers prior to the deadline of Solicitation

Responses. Amended answers will be posted on the eGrants and ESBD website. It is Respondent's responsibility to check the eGrants and ESBD website or contact the point of contact for updated responses. The System Agency also reserves the right to provide a single consolidated response of all similar questions in any manner at the System Agencies sole discretion.

3.5 Solicitation Response Composition

3.5.1 Generally

All Applications must be:

A. Clearly legible;
B. Sequentially page-numbered and include the Respondents name at the top of each page;
C. Organized in the sequence outlined in **Article VIII** - Submission Checklist;
D. In Arial or Times New Roman font, size 12 or larger for normal text, no less than size 10 for tables, graphs, and appendices;
E. Blank forms provided in the attachments must be used (electronic reproduction of the forms is acceptable; however, all forms must be identical to the original form(s) provided); do not change the font used on forms provided;
F. Correctly identified with the RFA number and submittal deadline;
G. Responsive to all RFA requirements; and
H. Signed by an authorized official in each place a signature is needed (copies must be signed but need not bear an original signature).

3.5.2 Submission in Separate Parts

Respondents must submit their Application in separate parts as follows:

A. Administrative information, including all forms;
B. Narrative application, including all forms;
C. Expenditure request and performance measures; and
D. Applicable exhibits and required forms.

Paper documents (i.e., the original and all hard copies) must be separated by parts. Electronic submissions must be separated by electronic medium used for submission (i.e., flash drive).

The entire Solicitation Response—all separated paper documents and electronic copies—must then be submitted in one package to HHSC at the address listed in **Section 3.6.3**. The number of copies and directions for submitting an "Original" and "Copies" are outlined in **Section 8.2.**

3.5.3 Submission

A. Respondent must Submit one (1) original and one (1) paper copy of the RFA, organized as instructed in **Section 3.5.2**. An authorized representative must sign the original in ink.

B. Submit five (5) USB flash drives compatible with Microsoft Office 2010, each containing both the Grant Application and all required forms.

HHSC will not accept telephone and facsimile applications. Any disparities between the contents of the original printed application and the electronic application will be interpreted in favor of HHSC.

3.6 Solicitation Response Submission and Delivery

3.6.1 Deadline

Solicitation Responses must be received at the address in **Section 3.6.3** time-stamped by the System Agency no later than the date and time specified in **Section 3.1**.

3.6.2 Labeling

Solicitation Responses shall be placed in a sealed box and clearly labeled as follows:

EVENT NAME AND NUMBER:	Title V Maternal and Child Health Fee-for-Service Program HHS0001365
EVENT DATE AND TIME:	Monday, March 4, 2019 at 2:00 PM Central Time
RESPONDENTS NAME:	_____
PURCHASER'S NAME:	Colette Norman, CTCD, CTCM

The System Agency will not be held responsible for any Solicitation Response that is mishandled prior to receipt by the System Agency. It is Respondent's responsibility to mark appropriately and deliver the Solicitation Response to the System Agency by the specified date and time.

3.6.3 Delivery

Respondent must deliver Solicitation Responses by one of the methods below to the address noted. Solicitation Responses submitted by any other method (e.g. facsimile, telephone, email) will NOT be considered.

To be delivered by U.S. Postal Service, overnight or express mail, or hand delivery to:

HHSC Procurement and Contracting Services ("PCS")
Bid Room
Attn: Colette Norman, CTCD, CTCM
1100 W. 49th Street, MC 2020
Service Building (Building S)
Austin, Texas 78756

Note: All Solicitation Responses become the property of HHSC after submission and will not be returned to Respondent.

3.6.4 Alterations, Modifications, and Withdrawals

Prior to the Solicitation submission deadline, a Respondent may: (1) withdraw its Solicitation Response by submitting a written request to the point of contact identified in **Section 3.4.1**; or (2) modify its Solicitation Response by submitting a written amendment to the point of contact identified in **Section 3.4.1**. The System Agency may request Solicitation Response Modifications at any time.

ARTICLE IV. SOLICITATION RESPONSE EVALUATION AND AWARD PROCESS

4.1 GENERALLY

Those Respondents making it through the initial review process will be invited to submit additional information and to participate in a negotiation process which will determine final selection. The specific dollar amount awarded to each successful Respondent will depend upon the merit and scope of the application and negotiations. Funded amounts may differ from those requested. Not all Respondents who are deemed eligible to receive funds are assured of receiving an award.

The final funding amount and the provisions of the contract will be determined at the sole discretion of DSHS.

A three-step selection process will be used:

A. Eligibility screening;
B. Evaluation based upon specific selection criteria; and
C. Final Selection based upon state priorities.

4.2 ELIGIBILITY SCREENING

Applications will be reviewed for eligibility requirements and completeness. All complete Applications meeting the minimum eligibility requirements will move to the evaluation stage.

4.3 EVALUATION

HHSC will select Respondents to receive awards based on evaluation scores, geographic distribution, and the best interest of the State. Applications will be evaluated and scored in accordance with the factors deemed relevant by HHSC.

4.3.1 Specific Evaluation Criteria

Grant applications shall be evaluated based upon the following criteria and weights. See also, **Exhibit H: Evaluation Tool**.

A. Respondent Readiness (20%);

B. Respondent Background, including previous experience with grants and contracts (30%);

C. Assessment Narrative (10%);

D. Service Delivery Plan (30%); and

E. Expenditure Request and Performance Measures (10%).

4.4 FINAL SELECTION

After initial screening for eligibility, application completeness, and initial scoring of the elements listed above in **Sections 4.3**, a selection committee will look at all eligible applicants to determine which applications should be awarded in order to most effectively accomplish state priorities. The selection committee will recommend grant awards to be made to the HHSC Executive Commissioner, who will make the final award approval.

HHSC will make all final funding decisions based on eligibility, Respondent's capacity to deliver services as defined in the RFA, geographic distribution across the state, state priorities, reasonableness, availability of funding, and cost-effectiveness.

4.5 NEGOTIATION AND AWARD

The specific dollar amount awarded to each successful Applicant will depend upon the merit and scope of the Application, the recommendation of the selection committee, and the decision of the Executive Commissioner.

Not all Applicants who are deemed eligible to receive funds are assured of receiving an award.

The negotiation phase will involve direct contact between the successful Applicant and the Purchaser via phone and/or email. During negotiations, successful Applicants may expect:

A. An in-depth discussion of the submitted application and budget; and

B. Requests from HHSC for clarification or additional detail regarding submitted Application.

The final funding amount and the provisions of the contract will be determined at the sole discretion of HHSC staff.

HHSC may announce tentative or apparent grant recipients once the Executive Commissioner has given approval to initiate negotiation and execute contracts.

Any exceptions to the requirements, terms, conditions, or certifications in the RFA or attachments, Addendums, or revisions to the RFA or general provisions, sought by the Applicant must be specifically detailed in writing by the Applicant on Exhibit G: Exceptions and Assumptions Form in this application and submitted to HHSC for consideration. HHSC will accept or reject each proposed exception. HHSC will not consider exceptions submitted separately from the application or at a later date.

HHSC will post to the eGrants Website and may publicly announce a list of Applicants whose Applications are selected for final award. This posting does not constitute HHSC's agreement with all the terms of any Applicant's application and does not bind HHSC to enter into a contract with any Applicant whose award is posted.

4.6 Questions or Requests for Clarification By the System Agency

The System Agency reserves the right to ask questions or request clarification from any Respondent at any time during the application process.

ARTICLE V. NARRATIVE APPLICATION

5.1 Narrative Application

5.1.1 Executive Summary

Provide a high-level overview of the Respondent's approach to meeting the RFA's requirements. The summary must demonstrate an understanding of the goals and objectives of the grant program.

5.1.2 Project Work Plan

Utilizing the application forms, A through S attached to this RFA, Respondents will describe the proposed services, processes, and methodologies for meeting all components described in **Article II**. Respondent should identify all tasks to be performed, including all project activities, to take place during the grant funding period. Respondent will also include all documents requested as part of completing forms to demonstrate fulfilling **Article II** requirements.

5.1.3 Respondent Readiness

5.1.3.1 Definition

Acceptable readiness is defined as the Respondent's ability to meet program and contractual requirements, the capacity to achieve service levels based on awarded funds, and the following attributes to support a given service:

A. Administrative and board support for the service;
B. Physical infrastructure;
C. Clinical infrastructure;
D. Demonstrable experience in providing similar services; and
E. Financial stability.

5.1.3.2 Purpose

To ensure that Respondents have the required readiness elements in place to allow the provision of services should a contract be awarded, Respondents will be evaluated and scored on the readiness criteria outlined below. HHSC reserves the right to perform on-site and/or desk reviews for Respondents scoring low on any portion of the readiness component of this application. If HHSC determines that the Respondent is not sufficiently ready to perform, then HHSC reserves the right not to enter into a contract with the Respondent.

5.1.3.3 Administrative and Board Support

Respondents must demonstrate adequate administrative and board support through descriptions of their organizations, and by submitting current organization charts (see **Form D: Respondent Background**). The chart must include the appropriate oversight structure (e.g., board, city council, county commissioners, etc.), CEO, CFO, medical and/or dental director licensed by the State of Texas and in good standing, and a staffing structure that will support service provision. The description must include:

A. An executive summary describing the organization's vision, mission, and values statements, along with a description of how the board of directors is involved in the operations of the organization (see **Form D: Respondent Background**);
B. A detailed description of the organizational structure, management systems, and lines of authority that are appropriate and adequate for the size and scope of the organization (see **Form D: Respondent Background**);
C. Table of Contents from organization's operating policies and procedures (see **Form M - Service Delivery Plan for Child Health & Child Dental Services** and **Form Q: Service Delivery Plan for Prenatal Medical & Prenatal Dental Services**);
D. Resumes/curriculum vitae for the CEO, CFO, medical director licensed by the State of Texas and in good standing (including State of Texas medical license number and DEA number) and/or dental director licensed by the State of Texas and in good standing (including State of Texas dental license number), and clinical/program director (see **Form D: Respondent Background**);
E. Employee job descriptions (see **Form D: Respondent Background**);
F. Medicaid billing number for the organization, or application for Medicaid billing number (see **Form A: Face Page**);
G. Timeline for annual independent financial audit (see **Form B: Administrative Information**);
H. Description of the organization's outreach plan (e.g., media releases, outreach strategies for marketing organization to community) for the funded services (see **Form M: Service Delivery Plan for Child Health & Child Dental Services** and **Form Q: Service Delivery Plan for Prenatal Medical & Prenatal Dental Services)**; and
I. Agency's quality assurance process (see **Form M: Service Delivery Plan for Child Health & Child Dental Services** and **Form Q: Service Delivery Plan for Prenatal Medical & Prenatal Dental Services**).

5.1.3.4 Physical Infrastructure

Respondents must have an adequate physical infrastructure to support the provision of services. At a minimum, Respondents must have the following physical infrastructure in place:

A. Space for clinical and administrative staff (see **Form F: Respondent Site Readiness**);
B. Data and financial management systems, including secure confidential data storage (see **Form M: Service Delivery Plan for Child Health & Child Dental Services** and **Form Q: Service Delivery Plan for Prenatal Medical & Prenatal Dental Services**);
C. Computer systems with the following minimum functionality (see **Form F: Respondent Site Readiness**):
    1. Internet Browser - minimum Internet Explorer ("IE") 10; recommend IE 11 or newer;

2. Microsoft Office - minimum 2010 Office Suite; recommend 2013 Office Suite;
3. Email Client; and

D. Appropriate signage to identify funded entity (see **Form F: Respondent Site Readiness**).

5.1.3.5 Clinical Infrastructure

Respondents must have a clinical infrastructure appropriate to support the provision of services. At a minimum, Respondents must have the following in place:

A. Handicap-accessible clinic site(s) that is/are geographically close to the target population (see **Form F: Respondent Site Readiness**);
B. Appropriate facility(ies) where services can be delivered with clean exam rooms, space for Client intake, and a place for Clients to wait (see **Form F: Respondent Site Readiness**);
C. Locked storage for charts, records, medications, and medical supplies (see **Form F: Respondent Site Readiness**);
D. Proper disposal for medical waste (see **Form F: Respondent Site Readiness**);
E. Clinicians who are licensed by the State of Texas to provide the type of services for which funding is requested (see **Form D: Respondent Background**);
F. Medical director licensed by the State of Texas and in good standing and/or dental director licensed by the State of Texas and in good standing to practice dentistry in Texas (see **Form D: Respondent Background**);
G. Eligibility and billing staff who are trained or will be trained in requirements for funded services (see **Form M: Service Delivery Plan for Child Health & Child Dental Services** and **Form Q: Service Delivery Plan for Prenatal Medical & Prenatal Dental Services**);
H. Staff to manage clinic operations (see **Form D: Respondent Background**);
I. Clinicians that have Medicaid numbers and can bill for services (see **Form D: Respondent Background**);
J. Current written protocols and Standing Delegation Orders (see **Form H: Title V Fee for Service Program Assurances**);
K. Current Prescriptive Authority Agreement for Advance Practice Providers ("APN" and/or "PA");
L. CLIA certification appropriate for the level of tests performed **(**see **Form F: Respondent Site Readiness**);
M. Quality Management Policy; and
N. Primary license verification annually for all licensed personnel.

5.1.3.6 Demonstrable Experience in Providing Similar Services

Describe past experience(s) providing child health, child dental, prenatal medical, and/or prenatal dental services, applicable to Respondents Application. (See **Form D: Respondent Background)**.

ARTICLE VI. REQUIRED RESPONDENT INFORMATION

6.1 ADMINISTRATIVE ENTITY INFORMATION

Using **Form D: Respondent Background** Respondent must provide satisfactory evidence of its ability to manage and coordinate the types of activities described in this Solicitation.

6.2 LITIGATION AND CONTRACT HISTORY

Respondent must include in its Solicitation Response a complete disclosure of any alleged or significant contractual failures.

In addition, Respondent must disclose any civil or criminal litigation or investigation pending over the last five (5) years that involves Respondent or in which Respondent has been judged guilty or liable. Failure to comply with the terms of this provision may disqualify Respondent.

Solicitation Response may be rejected based upon Respondent's prior history with the State of Texas or with any other party that demonstrates, without limitation, unsatisfactory performance, adversarial or contentious demeanor, or significant failure(s) to meet contractual obligations.

6.3 CONFLICTS

Using **Form B: Administrative Information**, Respondent must certify that it does not have any personal or business interests that present a conflict of interest with respect to the RFA and any resulting contract. Additionally, if applicable, the Respondent must disclose all potential conflicts of interest. The Respondent must describe the measures it will take to ensure that there will be no actual conflict of interest and that its fairness, independence and objectivity will be maintained. The System Agency will determine to what extent, if any, a potential conflict of interest can be mitigated and managed during the term of the contract. Failure to identify actual and potential conflicts of interest may result in disqualification of a Solicitation Response or termination of a contract.

Please include any activities of affiliated or parent organizations and individuals who may be assigned to this contract, if any.

Additionally, pursuant to Section 2252.908 of the Texas Government Code, a successful Respondent awarded a contract greater than $1 million dollars must submit a disclosure of interested parties to the state agency at the time the business entity submits the signed contract. Rules and filing instructions may be found on the Texas Ethics Commissions public website and additional instructions will be given by HHSC to successful Respondents.

6.4 GRANT APPLICATION DISCLOSURE

In an effort to maximize state resources and reduce duplication of effort, HHSC, at its discretion, may require the Respondent to disclose information regarding the application for or award of state, federal,

and/or local grant funding by the Respondent or Community Collaborative member organization within the past two (2) years to provide medical or dental services to the Title V population.

6.5 AFFIRMATIONS AND CERTIFICATIONS

Respondent must complete and return all the following listed forms and exhibits. Exhibits are listed in **Article IX**.

A. **Exhibit A: Affirmations and Solicitation Acceptance**
B. **Exhibit C-1: Texas HHS System Data Use Agreement**
C. **Exhibit C-2: Security and Privacy Inquiry (SPI) Form**
D. **Exhibit D: Certification Regarding Lobbying**
E. **Exhibit E: Assurances - Non-Construction Programs**
F. **Exhibit F: Federal Funding Accountability and Transparency Act (FFATA) Certification**
G. **Exhibit G: Exceptions and Assumptions Form**, if applicable.

6.6 HUB

If a successful Respondent chooses to subcontract for goods and services using the funding awarded in this grant, HHSC encourages the Respondent to use HUBs to provide those goods and services where possible.

The remainder of this page is intentionally left blank.

ARTICLE VII. GENERAL TERMS AND CONDITIONS

7.1 General Conditions

7.1.1 Costs Incurred

Respondents understand that issuance of this Solicitation in no way constitutes a commitment by any System Agency to award a contract or to pay any costs incurred by a Respondent in the preparation of a response to this Solicitation. The System Agency is not liable for any costs incurred by a Respondent prior to issuance of or entering into a formal agreement, contract, or purchase order. Costs of developing Solicitation Responses, preparing for or participating in oral presentations and site visits, or any other similar expenses incurred by a Respondent are entirely the responsibility of the Respondent, and will not be reimbursed in any manner by the State of Texas.

7.1.2 Contract Responsibility

The System agency will look solely to Respondent for the performance of all contractual obligations that may result from an award based on this Solicitation. Respondent shall not be relieved of its obligations for any nonperformance by its Grantees.

7.1.3 Public Information Act

Solicitation Responses are subject to the Texas Public Information Act ("PIA"), Texas Government Code Chapter 552, and may be disclosed to the public upon request. Subject to the PIA, certain information may be protected from public release. Respondents who wish to protect portions of the Solicitation Response from public disclosure should familiarize themselves with this law. Information pertaining to the Solicitation will be withheld or released only in accordance with the PIA.

7.1.4 News Releases

Prior to final award a Respondent may not issue a press release or provide any information for public consumption regarding its participation in the procurement. Requests should be directed to the HHSC point of contact identified in **Section 3.4.1**.

7.1.5 Additional Information

By submitting an application, the Respondent grants HHSC the right to obtain information from any lawful source regarding the Respondent's and its directors', officers', and employees': (1) past business history, practices, and conduct; (2) ability to supply the goods and services; and (3) ability to comply with contract requirements. By submitting an application, a Respondent generally releases from liability and waives all claims against any party providing HHSC information about the Respondent. HHSC may take such information into consideration in evaluating applications.

ARTICLE VIII. SUBMISSION CHECKLIST

This checklist is provided for Respondent's convenience only and identifies documents that must be submitted with this Solicitation in order to be considered responsive. Any Solicitation Response received without these requisite documents may be deemed nonresponsive and may not be considered for contract award.

8.1 ORIGINAL SOLICITATION RESPONSE PACKAGE

The Solicitation Package must include the "Original" Solicitation Response in **hard-copy** consisting of the forms described in detail below, each under separate cover but packaged together and clearly labeled "Original" on each.

1. Administrative Information (Forms A through C)

___ Form A: Face Page
___ Form B: Administrative Information
___ Form C-1: Governmental Entity - Authorized Officials
___ Form C-2: Nonprofit or For-Profit Entity - Board of Directors and Principal Officers

2. Narrative Application Forms (Forms D through Q)

A. Forms to be completed by all Respondents (Forms D through I)

___ Form D: Respondent Background
___ Form E: Assessment Narrative
___ Form F: Respondent Site Readiness
___ Form G: Title V Clinic Sites
___ Form H: Title V Fee for Service Program Assurances
___ Form I: Child Support Certification

B. Forms to be completed by Respondents providing Child Health and/or Child Dental services (Forms J through M)

___ Form J: Title V Child Health and Child Dental Services, Texas Counties and Regions
___ Form K: Contact Person Information – Title V Child Health Services
___ Form L: Contact Person Information – Title V Child Dental Services
___ Form M: Service Delivery Plan for Child Health & Child Dental Services

C. Forms to be completed by Respondents providing Prenatal Medical and/or Prenatal Dental services (Forms N through Q)

___ Form N: Title V Prenatal Medical & Prenatal Dental Services, Texas Counties and Regions
___ Form O: Contact Person Information – Title V Prenatal Medical Services

___ Form P: Contact Person Information – Title V Prenatal Dental Services
___ Form Q: Service Delivery Plan for Prenatal Medical & Prenatal Dental Services

3. Expenditure Request and Performance Measures (Forms R-1 through S)

___ Form R-1: Title V Child Health & Dental Ceiling Request and Performance Measures
___ Form R-2: Title V Prenatal Medical & Prenatal Dental Ceiling Request and Performance Measures
___ Form S: Title V Subcontractor Information

4. Exhibits

___ Exhibit A: Affirmations and Solicitation Acceptance
___ Exhibit C-1: Texas HHS System Data Use Agreement
___ Exhibit C-2: Security and Privacy Inquiry (SPI) Form
___ Exhibit D: Certification Regarding Lobbying
___ Exhibit E: Assurances - Non-Construction Programs
___ Exhibit F: Federal Funding Accountability and Transparency Act (FFATA) Certification
___ Exhibit G: Exceptions and Assumptions Form, if applicable

8.2 COPIES OF SOLICITATION RESPONSE PACKAGE

Respondent will provide the following number of **electronic** copies (all clearly labeled as "copy") in addition to the hard-copy "Original" Solicitation Response. Electronic copies must be submitted on a USB drive and separated by folders.

a. Five (5) Electronic copies of **Original Solicitation Response package.**
b. Five (5) Electronic copies of **applicable exhibits.**

ARTICLE IX. LIST OF EXHIBITS AND FORMS

9.1 EXHIBITS

Exhibit A: Affirmations and Solicitation Acceptance
Exhibit B: HHSC Uniform Terms and Conditions – Grant Version 2.16
Exhibit C-1: Texas HHS System Data Use Agreement
Exhibit C-2: Security and Privacy Inquiry (SPI) Form
Exhibit D: Certification Regarding Lobbying
Exhibit E: Assurances - Non-Construction Programs
Exhibit F: Federal Funding Accountability and Transparency Act (FFATA) Certification
Exhibit G: Exceptions and Assumptions Form
Exhibit H: Evaluation Tool Template – Title V
Exhibit I: HHSC Special Conditions
Exhibit J: Fiscal Year 2017, Policies and Procedures Manual

9.2 FORMS

Form A: Face Page
Form B: Administrative Information
Form C-1: Governmental Entity - Authorized Officials
Form C-2: Nonprofit or For-Profit Entity - Board of Directors and Principal Officers
Form D: Respondent Background
Form E: Assessment Narrative
Form F: Respondent Site Readiness
Form G: Title V Clinic Sites
Form H: Title V Fee for Service Program Assurances
Form I: Child Support Certification
Form J: Title V Child Health and Child Dental Services, Texas Counties and Regions
Form K: Contact Person Information – Title V Child Health Services
Form L: Contact Person Information – Title V Child Dental Services
Form M: Service Delivery Plan for Child Health & Child Dental Services
Form N: Title V Prenatal Medical & Prenatal Dental Services, Texas Counties and Regions
Form O: Contact Person Information – Title V Prenatal Medical Services
Form P: Contact Person Information – Title V Prenatal Dental Services
Form Q: Service Delivery Plan for Prenatal Medical & Prenatal Dental Services
Form R-1: Title V Child Health & Dental Ceiling Request and Performance Measures
Form R-2: Title V Prenatal Medical & Prenatal Dental Ceiling Request and Performance Measures
Form S: Title V Subcontractor Information

9.3 ATTACHMENTS

Attachment A: Title V Services and Reimbursement Rates

FORM A: FACE PAGE

Application for Financial Assistance

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 application and must be completed in its entirety.

RESPONDENT INFORMATION							
1) LEGAL BUSINESS NAME:							
2) MAILING Address Information (include mailing address, street, city, county, state and zip code):							
3) PAYEE Name and Mailing Address (if different from above):							
4) a. Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or Social Security Number (9 digit): 4. b. DUNS Number							
**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) Medicaid Provider Number:			OR	Date Medicaid Application Submitted & TMHP Ticket #:			
6) TYPE OF ENTITY (check all that apply):							
	☐	City	☐	Nonprofit Organization*	☐	Individual	
	☐	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:*							
7) PROPOSED BUDGET PERIOD:		Start Date:		End Date:			
8) COUNTIES SERVED BY PROJECT: Include completed list of counties to be served behind Face Page per Title V funded service(s).							
9) AMOUNT OF FUNDING REQUESTED		V-CH & CD: $					
		V-PM & PD $		11) PROJECT CONTACT PERSON			
10) PROJECTED EXPENDITURES		$		Name: Phone: Fax: E-mail:			
Does Respondent's projected state or federal expenditures exceed $500,000 for Respondent's current fiscal year (excluding amount requested in line 9 above)? ** Yes ☐ No ☐ ***Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non-project-related HHSC funds.*				12) FINANCIAL OFFICER Name: Phone: Fax: E-mail:			
The facts affirmed by me in this application are truthful and I warrant the Respondent is in compliance with the assurances and certifications contained in the application. 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					14) SIGNATURE OF AUTHORIZED REPRESENTATIVE		
	Name: Title: Phone: Fax:						
					15) DATE		

FORM A: FACE PAGE INSTRUCTIONS

This form provides basic information about the Respondent and the proposed project with the Health and Human Services Commission ("HHSC"), including the signature of the authorized representative. It is the cover page of the application and is required to be completed. Signature affirms the facts contained in the Respondent's response are truthful and the Respondent is in compliance with the assurances and certifications contained in Exhibit A: Affirmation and Solicitation Acceptance 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 Respondent's application.

1. LEGAL BUSINESS NAME - Enter the legal name of the Respondent.

2. MAILING ADDRESS INFORMATION - Enter the Respondent's complete physical address and mailing address, city, county, state, and zip code.

3. PAYEE NAME AND MAILING ADDRESS - Payee – Entity involved in a contractual relationship with Respondent to receive payment for services rendered by Respondent 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 Respondent. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4. A. 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 Respondent acknowledges, understands and agrees 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.
   B. DUNS Number - 9-digit Dun and Bradstreet Data Universal Numbering System ("DUNS") number. This number is required if receiving ANY federal funds band can be obtained at: http://fe3dgov.dnb.com/webform

5. MEDICAID PROVIDER NUMBER OR DATE MEDICAID APPLICATION SUBMITTED – Enter the Medicaid provider number used by the organization to bill Medicaid. If the organization does not have a Medicaid number, enter the date an application was submitted to obtain a Medicaid number and TMPH Ticket #.

6. 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 Comptroller's Texas Procurement and Support Services 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.

7. PROPOSED BUDGET PERIOD - Enter the budget period for this application. Budget period is defined in the application

8. COUNTIES SERVED BY PROJECT – Check off counties to be served from the list of Texas counties provided (below) and include behind the Face Page per Title V funded service for which you are applying. Complete Form J: Title V Child Health & Child Dental Services - Texas Counties and Regions and/or Form N: Title V Prenatal Medical & Prenatal Dental Services - Texas Counties and Regions. Do not write counties on line 8. Do check the counties to be served on the counties list page.

9. AMOUNT OF FUNDING REQUESTED - Enter the amount of funding requested from HHSC for each type of funding requested. V-CH & CD (Child Health & Child Dental) amount must match the Grand Total of Form R-1 Title V Child Health & Child Dental Ceiling Request and Performance Measures. V-PM & PD (Prenatal Medical & Prenatal Dental) amount must match the Grand Total of Form R-2: Title V Prenatal Medical & Prenatal Dental Ceiling Request and Performance Measures.

10. PROJECTED EXPENDITURES - If Respondent's projected state or federal expenditures exceed $500,000 for Rspondent's current fiscal year, Respondent must arrange for a financial compliance audit (Single Audit).

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

12. FINANCIAL OFFICER - Enter the name, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.

13. AUTHORIZED REPRESENTATIVE - Enter the name, title, phone, fax, and e-mail address of the person authorized to represent the Respondent. Check the "Check if change" box if the authorized representative is different from previous submission to HHSC.

14. SIGNATURE OF AUTHORIZED REPRESENTATIVE - The person authorized to represent the Respondent must sign in this blank.

15. DATE - Enter the date the authorized representative signed this form.

FORM B: ADMINISTRATIVE INFORMATION

This form provides information regarding identification and contract history of the Respondent, executive management, project management, governing board members, and/or principal officers. Respond to each request for information ***or provide the required supplemental document behind this form.*** *If responses require multiple pages, identify the supporting pages/documentation with the applicable request.*

NOTE: Administrative Information may be used in screening and/or evaluating applications.

Legal Business Name of Respondent: _____

1. The Respondent must attach the following information:

If a Governmental Entity

- Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the Respondent.

If a Nonprofit or For Profit Entity

- Full names (last, first, middle), addresses, telephone numbers, titles and occupation of members of the Board of Directors or any other principal officers. Indicate the office held by each member (e.g. chairperson, president, vice-president, treasurer, etc.).
- Full names (last, first, middle), and addresses for each partner, officer, and director as well as the full names and addresses for each person who owns five percent (5%) or more of the stock if Respondent is a for-profit entity.

2. Is Respondent a nonprofit organization?

☐ **YES** ☐ **NO**

If YES, Respondent must include evidence of its nonprofit status with the application. Any one of the following is acceptable evidence. Check the appropriate box for the attached evidence.

☐ (a) A copy of a currently valid IRS exemption certificate.

☐ (b) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the Respondent organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

☐ (c) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

☐ (d) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the Respondent organization is a local nonprofit affiliate.

Conflict of Interest and Contract History

The Respondent must disclose any existing or potential conflict of interest relative to the performance of the requirements of this application. Examples of potential conflicts include an existing or potential business or personal relationship between the Respondent, its principal, or any affiliate or subcontractor, with the Health and Human Services Commission (HHSC) or any other entity or person involved in any way in any project that is the subject of this application. Similarly, any existing or potential personal or business relationship between the Respondent, the principals, or any affiliate or subcontractor, with any employee of the Health and Human Services Commission must be disclosed. Any such relationship that might be perceived, or represented as a conflict, must be disclosed. Failure to disclose any such relationship may be cause for contract termination or disqualification of the application. If, following a review of this information, it is determined by HHSC that a conflict of interest exists, the Respondent may be disqualified from further consideration for the award of a contract.

Pursuant to Texas Government Code Section 2155.004, a Respondent is ineligible to receive an award under this application if the bid includes financial participation with the Respondent by a person who received compensation from HHSC to participate in preparing the specifications or the application on which the bid is based.

3. **Does anyone in the Respondent organization have an existing or potential conflict of interest relative to the performance of the requirements of this application?**

   ☐ **YES** ☐ **NO**

   If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)

4. **Will any person who received compensation from HHSC for participating in the preparation of the specifications or documentation for this application participate financially with Respondent as a result of an award under this application?**

   ☐ **YES** ☐ **NO**

   If YES, indicate his/her name, job title, agency employed by, separation date, and reason for separation.

5. **Will any provision of services or other performance under any contract that many result from this application constitute an actual or potential conflict of interest or create the appearance of impropriety?**

   ☐ **YES** ☐ **NO**

   If YES, detail any such actual or potential conflict of interest that might be perceived or represented as a conflict. (Attach no more than one additional page.)

6. **Are any current or former employees of the Respondent current or former employees of HHSC (within the last 24 months)?**

   ☐ **YES** ☐ **NO**

   If YES, indicate his/her name, job title, separation date and reason for separation.

7. **Are any proposed personnel related to any current or former employees of HHSC?**

   ☐ **YES** ☐ **NO**

   If Yes, indicate his/her name, job title, separation date and reason for separation.

8. Has any member of Respondent's executive management, project management, governing board or principal officers been employee by HHSC 24 months prior to the application due date?

☐ **YES** ☐ **NO**

If YES, indicate his/her name, job title, separation date and reason for separation.

9. If the Respondent is a private nonprofit organization, does the executive director or other staff serve as voting members on the organization's governing board?

☐ **YES** ☐ **NO**

10. Is Respondent or any member of Respondent's executive management, project management, board members or principal officers:
- **Delinquent on any state, federal or other debt;**
- **Affiliated with an organization which is delinquent on any state, federal or other debt; or**
- **In default on an agreed repayment schedule with any funding organization?**

☐ **YES** ☐ **NO**

If YES, please explain. (Attach no more than one additional page.)

11. Has the Respondent had a contract suspended or terminated prior to expiration of contract or not been renewed under an optional renewal by any local, state, or federal department or agency or non-profit entity?

☐ **YES** ☐ **NO**

If YES, indicate the reason for such action that includes the name and contact information of the local, state, or federal department or agency, the date of the contract and a contract reference number, and provide copies of any and all decisions or orders related to the suspension, termination, or non-renewal by the contracting entity.

12. Does this application include financial participation by a person or entity that has been convicted of violating federal law, or been assessed a penalty in a federal civil administrative enforcement action, in connection with a contract awarded by the federal government for relief, recovery or reconstruction efforts as a result of Hurricanes Rita or Katrina or any other disaster occurring after September 24, 2005, under Government Code §2155.006 and 2161.053?

☐ **YES** ☐ **NO**

If YES, please explain. (Attach no more than one additional page.)

13. Has the Respondent had a contract with HHSC within the past 24 months?

☐ **YES** ☐ **NO**

If YES, please list the HHSC contract number and term

***If NO*, Respondent must be able to demonstrate fiscal solvency**. *Submit a copy of the organization's most recently audited balance sheet, statement of income and expenses and accompanying financial footnotes. If an organization does not have audited financial statements, submit a copy of the organization's most recent **IRS Form 990** and an explanation why an audited financial statement is not available. HHSC will review the documents that are submitted and may, at its sole discretion, reject the application on the grounds of the Respondent's financial capability.*

ALL ADDITIONAL PAGES REQUIRED BY RESPONSES TO FORM B: ADMINISTRATIVE INFORMATION SHOULD BE INSERTED HERE.

FORM C-1: Governmental Entity - Authorized Officials

Legal Business Name: ____________________

Include the full names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the Respondent.

Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________
Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________
Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	.	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________
Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________
Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________

FORM C-2: NONPROFIT OR FOR-PROFIT ENTITY - Board of Directors and Principal Officers

Legal Business Name: ____

Include the full names (last, first, middle), addresses, telephone numbers, and titles of members of the Board of Directors or any other principal officers. Indicate the office/title held by each (e.g. chairperson, president, vice-president, treasurer, etc.).In addition, if entity is a for-profit, include the full names and addresses for each person who owns five percent (5%) or more of the stock.

Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________
Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________
Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________
Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________
Name:	____________________	Mailing Address (incl. street, city, county, state, & zip):
Title:	____________________	____________________
Phone:	____________________	____________________
Fax:	____________________	____________________
E-mail:	____________________	____________________

Board of Directors and Principal Officers (cont.)

Name: Title: Phone: Fax: E-mail:		Mailing Address (incl. street, city, county, state, & zip):
Name: Title: Phone: Fax: E-mail:		Mailing Address (incl. street, city, county, state, & zip):
Name: Title: Phone: Fax: E-mail:	.	Mailing Address (incl. street, city, county, state, & zip):
Name: Title: Phone: Fax: E-mail:		Mailing Address (incl. street, city, county, state, & zip):
Name: Title: Phone: Fax: E-mail:		Mailing Address (incl. street, city, county, state, & zip):
Name: Title: Phone: Fax: E-mail:		Mailing Address (incl. street, city, county, state, & zip):

FORM D: RESPONDENT BACKGROUND

Legal Business Name of Respondent: _____

Respondent must provide a narrative description of its organization, staff, systems, and oversight structure (see RESPONDENT BACKGROUND GUIDELINES). Organizational charts, resumes/curriculum vitae, and job descriptions are to be placed following **Form D: Respondent Background** or at the end of the application and are not included in the page limit. A maximum of **two (2)** additional pages may be attached if needed for a total of three (3) pages.

FORM D: RESPONDENT BACKGROUND GUIDELINES

Respondent must provide a narrative description of its organization, staff, systems and oversight structure in response to the following items, numbering them as indicated:

1. Provide an executive summary describing the organization's vision, mission and values statements, along with a description of how the board of directors is involved in the operations of the organization.

2. Describe past experience(s) providing Child Health, Child Dental, Prenatal Medical, and/or Prenatal Dental services. (Respondent only needs to address the Title V funded service or services for which they are applying.)

3. Provide a detailed description of the organizational structure, management systems and lines of authority that are appropriate and adequate for the size and scope of the organization.

4. Provide a current organization chart and the resumes/curriculum vitae for the CEO, CFO, Medical Director licensed to practice medicine in Texas (including his/her State of Texas Medical License Number), Dental Director licensed to practice dentistry in Texas (including his/her State of Texas Dental License Number), and Clinical/Program Director. The organization chart must include the appropriate oversight structure (e.g., Board, City Council, County Commissioners, etc.), CEO, CFO, Medical Director, Dental Director and a staffing structure that will support service provision. On the chart, identify the staff who manages clinic operations.

5. Provide job descriptions for the following key employees, i.e., Medical Director, Dental Director, Clinical/Program Director, eligibility and billing staff, and clinicians.

FORM E: ASSESSMENT NARRATIVE

Legal Business Name of Respondent: _____

Respondent must provide a narrative description addressing each of the assessment items (see ASSESSMENT NARRATIVE GUIDELINES) associated with the services proposed in this application. A maximum of **four** (4) additional pages may be attached if needed for a total of five (5) pages).

FORM E: ASSESSMENT NARRATIVE GUIDELINES

Specifically address each of the assessment items listed below associated with the services proposed in this application, numbering them as indicated. Multiple data sources and assessments exist for many communities. Respondent is encouraged to utilize these resources when completing this form.

1. Provide brief synopsis of the community as a whole describing in general:

    a. Geographic boundaries (urban or rural, physical environment);
    b. General demographic data (age, gender, ethnicity, etc.);
    c. General socioeconomic data (per capita income, poverty levels, uninsured/underinsured, unemployment, occupational data, etc.); and
    d. General description of community-wide health status (e.g., low birth weight, obesity of children, adolescents and pregnant women, immunization rate, and morbidity/mortality statistics).

2. Describe the target population(s) including:

    a. Geographic service area;
    b. Characteristics of target population (including demographic and socioeconomic data specific to each population);
    c. Target population's health status (including population data related to health indicators, behavioral data, and community opinion data); and
    d. Current population served (characteristics, population data, numbers of Clients served, types and numbers of services provided).

3. Describe gaps in resources and potential barriers to improving health status.

4. Are there any other characteristics of the populations(s) you propose to serve or of the proposed service area(s) which make Title V support particularly important?

FORM F: RESPONDENT SITE READINESS

Legal Business Name of Respondent: _____

Appropriate signage to identify funded entity.	☐	Y	☐	N
Space for clinical and administrative staff.	☐	Y	☐	N
Data and financial management systems, including secure confidential data storage.				
Computer systems with following minimum functionality:				
• Internet - minimum Internet Explorer (IE) 10; recommend IE 11 or newer	☐	Y	☐	N
• Microsoft Office minimum 2010 Office Suite; recommended 2013 Office Suite	☐	Y	☐	N
• Email Client	☐	Y	☐	N
Locked storage for charts, records, medications and medical supplies	☐	Y	☐	N
Proper disposal for medical waste	☐	Y	☐	N
CLIA certification for level of tests performed	☐	Y	☐	N
Handicap-accessible clinic sites that are geographically close to target population	☐	Y	☐	N
Appropriate facility(ies) where services can be delivered with clean exam rooms, space for client intake, and a place for Clients to wait.	☐	Y	☐	N
Appropriate use of interpreter services and language translation (including resources for both).	☐	Y	☐	N
Compliance with Americans with Disabilities Act ("ADA") requirements	☐	Y	☐	N
Extended hours and weekend hours for delivery of services, as appropriate.	☐	Y	☐	N

FORM G: TITLE V CLINIC SITES

COMPLETE A SEPARATE FORM FOR EACH CLINIC SITE

Legal Business Name of Respondent:	Clinic Site # __ of ___

CLINIC SITE INFORMATION:

Service Area (counties to be served by this clinic site):											
Funding Sources Used to Support this Clinic:	☐	BCCS	☐	FP	☐	PHC	☐	Epilepsy	☐	WIC	
	☐	FQHC	☐	FQHC Look-alike	☐	Open Extended Hours					
	☐	V – Child Health	☐	V – Prenatal Medical							
	☐	V-Child Dental	☐	V – Prenatal Dental							
Subcontractor Site:	☐	Yes	☐	No							
Clinic Name to Appear on Website Locator:											
Contact Person:					Phone:						
Location of Site:					Fax:						
Street Address:											
City:		County:		Zip Code:		HHSC Region:					
Pharmacy License #:		TPI #:		NPI#:							

CLINIC HOURS AND SERVICES:

DAY		HOURS OF OPERATION From	HOURS OF OPERATION To	SERVICES PROVIDED/CLINIC TYPE	# MONTHLY CLINICS
MONDAY	Morning				
	Afternoon				
	Evening (After 5 PM)				
TUESDAY	Morning				
	Afternoon				
	Evening (After 5 PM)				
WEDNESDAY	Morning				
	Afternoon				
	Evening (After 5 PM)				
THURSDAY	Morning				
	Afternoon				
	Evening (After 5 PM)				
FRIDAY	Morning				
	Afternoon				
	Evening (After 5 PM)				
SATURDAY	Morning				
	Afternoon				
	Evening (After 5 PM)				
SUNDAY	Morning				
	Afternoon				
	Evening (After 5 PM)				
TOTAL HOURS/MONTH				TOTAL # CLINICS PER MONTH	

PROGRAM SPECIFICS:

Check all that apply for TV Child Health, Child Dental, Prenatal Medical, and Prenatal Dental Services	
☐ Appointment scheduling on site	☐ Site does client intake and/or eligibility determination
☐ Child Health services provided on site	☐ Prenatal Medical services provided on site
☐ Child/Adolescent Dental services provided on site	☐ Prenatal Dental services provided on site
☐ Enrolled as a Texas Health Steps Provider	☐ Enrolled as a CHIP Provider

FORM G: CLINIC SITE FORM INSTRUCTIONS

Complete a separate Clinic Site Form for each clinic site. Information provided on clinic site forms is used to update HHSC websites and public databases, therefore, each clinic form must contain current and accurate information.

Legal Name of Respondent	Respondent's legal name.
Clinic Site # ___ of ___	Example: Clinic Site #1 of 5 for the first clinic site out of five clinic sites, Clinic Site #2 of 5 for the second clinic site of five, etc.
CLINIC SITE INFORMATION:	
Service Area	List counties served by that specific clinic site, NOT all counties served by the whole project.
Funding Sources Used to Support this Clinic	From the sources listed, check all sources of funds used to support that specific clinic site.
Subcontractor Site	For each clinic site, indicate whether that particular site is subcontracted by the Respondent to another entity for the provision of services.
Clinic Name to Appear on Website Locator	State the name of the clinic as it will appear on the HHSC website locator. (The name should be recognizable to Clients.)
Contact Person	Name of contact person for that clinic site.
Phone	Phone number for the clinic.
Location of Site	Clinic location (e.g., Texas Medical Center/Smith Tower)
Fax	Fax number for the clinic.
Street Address	Physical address of clinic.
City/County/Zip Code	City, county and zip code of clinic.
HHSC region	HHSC Region where clinic is located.
Pharmacy License #	Pharmacy license number for the clinic (if applicable); otherwise put N/A for Not Applicable.
TPI#	Texas Provider Identifier # for the clinic (if applicable), otherwise N/A.
NPI#	National Provider Identifier # for the clinic (if applicable), or N/A.
CLINIC HOURS AND SERVICES:	
Hours of Operation	List the operating hours of each clinic site for each day of the week broken into morning (e.g., 8:00 a.m. – Noon), afternoon (e.g. 12:01 p.m. – 5:00 p.m.), and evening hours (e.g., 5:01 p.m. – 8:00 p.m.). Indicate days of the week when the clinic is closed (e.g. Tuesday – closed).
Services Provided/Clinic Type	List the type of services provided or type of clinic for each day of the week. For example, Monday = child health clinic, Wednesday = dental clinic, etc. **Legend** -C-child health, CD-child dental, PM-prenatal medical, PD-prenatal dental.
# Monthly Clinics	List the total number of clinics each month by the day of the week, e.g., Monday = 4 clinics per month; Tuesday = 0 clinics per month, etc.
Total Hours/Month	List the total number of hours of operation per month for each clinic site (e.g., Clinic Site 1 = 128 hours per month; Clinic Site 2 = 160 hours per month, etc.)
Total # Clinics Per Month	List the total number of clinics held per month per clinic site (e.g., Clinic Site 1 = 16, Clinic Site 2 = 20, etc.)

PROGRAM SPECIFICS:

This section of the clinic site form includes questions related to specific HHSC programs. Check the appropriate boxes to indicate what specific services are provided at each clinic site. Services generally vary between clinic sites, so it is essential that accurate service information is reported by Respondent in order for HHSC to appropriately monitor services provided. *Important: Any changes in clinic information, including programmatic or operational changes, must be reported **in writing** to the appropriate HHSC Contract Manager in a timely manner.*

FORM H: TITLE V FEE FOR SERVICE PROGRAM ASSURANCES

Legal Business Name of Respondent: _____

As the duly authorized representative of the Respondent, I certify that the Respondent agrees to comply with the requirements and intent of the Maternal and Child Health Services Title V Block Grant and all other requirements of the Health and Human Services Commission ("HHSC") which include, but are not limited to, the following:

1. Conduct Title V activities in a culturally sensitive and non-discriminating manner.

2. Conduct Title V activities as outlined in Respondent's application, and to notify the Manager of the Contract Development and Support Branch prior to any significant departures from this plan.

3. Return 100% of any generated program income to the Title V program that generated the funds.

4. Provide services regardless of client's inability to pay.

5. Continue to serve existing Title V eligible Clients even if awarded funds have been expended per the Policies and Procedures Manual for Title V Maternal & Child Health Fee-for-Service for Child Health, Dental and Prenatal.

6. Screen and refer Clients for Medicaid, CHIP, or other medical services assistance programs, and refer Clients to those funding sources for which they may be eligible. Title V funds must not be used to pay for services that are allowable for persons eligible for Medicaid or CHIP or who have other third party health insurance.

7. Provide HHSC with access to all data gathered or generated.

8. Agree to share data/information generated by the project, within constraints of confidentiality, with HHSC, other area local public health entities, local authorities and communities in order to eliminate duplication of effort.

9. Grant HHSC rights to all tangibles, patentable, or copyrightable products developed with Federal and State funds.

10. Make available for HHSC review, all promotional materials/media to be disseminated in conjunction with this Title V project.

11. Comply with all applicable Title V policies, procedures, and regulations.

12. Must be in compliance with the U.S. Health Insurance Portability and Accountability Act of 1996 ("HIPAA") established standards for protection of client privacy.

13. Establish orientation and in-service training plan for all project personnel for skills development and/or continuing education based on an assessment of training needs.

14. Ensure that Title V services will be performed under the supervision, direction, and responsibility of a qualified licensed physician, and current protocols and Standing Delegation Orders are in place.

15. Ensure that clinicians are in place who are licensed by the State of Texas to provide the type of services for which funding is requested.

16. Ensure that all registered nurses ("RNs") who perform child health exams following the Texas Health Steps periodicity schedule have completed the Texas Health Steps module entitled “Overview of Best Practices and Children’s Services” within 90 days of contract execution, and that RNs hired after contract execution complete the module within 90 days of hire.

_____ _____

Authorized Signature Date

FORM I: CHILD SUPPORT CERTIFICATION

(Required for all Respondents EXCEPT Nonprofit and Governmental Entities)

Child Support Certification

The Texas Family Code, §231.006, places certain restrictions on child support obligors. Contracts with governmental entities or nonprofit corporations are not subject to §231.006.

The contractor identified below is not a governmental entity or a nonprofit corporation and certifies to the following:

1. The contractor is: (check one)

   ☐ An individual or sole proprietor, or

   ☐ A business entity (corporation, partnership, joint venture, limited liability company, association, etc.)

2. The contractor certifies the following is a complete list of the names and social security numbers of either (A) the individual or sole proprietor who is the contractor or (B) each partner, shareholder, or owner with an ownership interest of at least 25% of the contractor/business entity: (attach additional sheet if necessary).

   (A) Printed Name: _____
   Social Security Number: _____
   (B) Printed Name: _____
   Social Security Number: _____

3. Under the Texas Family Code, §231.006, the contractor certifies that the individual or business entity named in this contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this contract may be terminated and payment withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor (who is more than 30 days delinquent) is the sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive the specified grant, loan or payment. The contractor understands that it is the contractor's responsibility to verify whether a child support obligor who is more than 30 days delinquent is the sole proprietor, partner, shareholder or owner with an ownership interest of at least 25%.

4. Printed Name of Contractor: _____

   Printed Name of Authorized Representative: _____

   Signing this Certification: _____

   Signature of Authorized Representative: _____

   Date: _____

FORM I: CHILD SUPPORT CERTIFICATION GUIDELINES

Form I is required by Texas Family Code, §231.006, and is designed to certify that anyone applying for funds under this application is not a child support obligor (a person who is more than 30 days delinquent).

This form is applicable to for-profit corporations, sole proprietors, individuals and partnerships. This form is NOT applicable to Governmental entities and non-profit corporations. These types of entities do not need to complete the form.

FORM J: Title V Child Health & Child Dental Services, Texas Counties and Regions
List in Alphabetical Order

Legal Business Name of Respondent: _____

COUNTIES SERVED BY PROJECT - This list is provided for item 8, **Form A: Face Page**.

Counties	☒	R	Counties	☒	R	Counties	☒	R	Counties	☒	R	Counties	☒	R
-A-			Crosby	☐	01	Hays	☐	07	Martin	☐	9/10	Schleicher	☐	9/10
Anderson	☐	4/5N	Culberson	☐	9/10	Hemphill	☐	01	Mason	☐	9/10	Scurry	☐	2/3
Andrews	☐	9/10	**-D-**			Henderson	☐	4/5N	Matagorda	☐	6/5S	Shackelford	☐	2/3
Angelina	☐	4/5N	Dallam	☐	01	Hidalgo	☐	11	Maverick	☐	08	Shelby	☐	4/5N
Aransas	☐	11	Dallas	☐	2/3	Hill	☐	07	McCulloch	☐	9/10	Sherman	☐	01
Archer	☐	2/3	Dawson	☐	9/10	Hockley	☐	01	McLennan	☐	07	Smith	☐	4/5N
Armstrong	☐	01	Deaf Smith	☐	01	Hood	☐	2/3	McMullen	☐	11	Somervell	☐	2/3
Atascosa	☐	08	Delta	☐	4/5N	Hopkins	☐	4/5N	Medina	☐	08	Starr	☐	11
Austin	☐	6/5S	Denton	☐	2/3	Houston	☐	4/5N	Menard	☐	9/10	Stephens	☐	2/3
-B-			DeWitt	☐	08	Howard	☐	9/10	Midland	☐	9/10	Sterling	☐	09
Bailey	☐	01	Dickens	☐	01	Hudspeth	☐	9/10	Milam	☐	07	Stonewall	☐	2/3
Bandera	☐	08	Dimmit	☐	08	Hunt	☐	2/3	Mills	☐	07	Sutton	☐	9/10
Bastrop	☐	07	Donley	☐	01	Hutchinson	☐	01	Mitchell	☐	2/3	Swisher	☐	01
Baylor	☐	2/3	Duval	☐	11	**-I-**			Montague	☐	2/3	**-T-**		
Bee	☐	11	**-E-**			Irion	☐	9/10	Montgomery	☐	6/5S	Tarrant	☐	2/3
Bell	☐	07	Eastland	☐	2/3	**-J-**			Moore	☐	01	Taylor	☐	2/3
Bexar	☐	08	Ector	☐	9/10	Jack	☐	2/3	Morris	☐	4/5N	Terrell	☐	9/10
Blanco	☐	07	Edwards	☐	08	Jackson	☐	08	Motley	☐	01	Terry	☐	01
Borden	☐	9/10	Ellis	☐	2/3	Jasper	☐	4/5N	**-N-**			Throckmorton	☐	2/3
Bosque	☐	07	El Paso	☐	9/10	Jeff Davis	☐	9/10	Nacogdoches	☐	4/5N	Titus	☐	4/5N
Bowie	☐	4/5N	Erath	☐	2/3	Jefferson	☐	6/5S	Navarro	☐	2/3	Tom Green	☐	9/10
Brazoria	☐	6/5S	**-F-**			Jim Hogg	☐	11	Newton	☐	4/5N	Travis	☐	07
Brazos	☐	07	Falls	☐	07	Jim Wells	☐	11	Nolan	☐	2/3	Trinity	☐	4/5N
Brewster	☐	9/10	Fannin	☐	2/3	Johnson	☐	2/3	Nueces	☐	11	Tyler	☐	4/5N
Briscoe	☐	01	Fayette	☐	07	Jones	☐	2/3	**-O-**			**-U-**		
Brooks	☐	11	Fisher	☐	2/3	**-K-**			Ochiltree	☐	01	Upshur	☐	4/5N
Brown	☐	2/3	Floyd	☐	01	Karnes	☐	08	Oldham	☐	01	Upton	☐	9/10
Burleson	☐	07	Foard	☐	2/3	Kaufman	☐	2/3	Orange	☐	6/5S	Uvalde	☐	08
Burnet	☐	07	Fort Bend	☐	6/5S	Kendall	☐	08	**-P-**			**-V-**		
-C-			Franklin	☐	4/5N	Kenedy	☐	11	Palo Pinto	☐	2/3	Val Verde	☐	08
Caldwell	☐	07	Freestone	☐	07	Kent	☐	2/3	Panola	☐	4/5N	Van Zandt	☐	4/5N
Calhoun	☐	08	Frio	☐	08	Kerr	☐	08	Parker	☐	2/3	Victoria	☐	08
Callahan	☐	2/3	**-G-**			Kimble	☐	9/10	Parmer	☐	01	**-W-**		
Cameron	☐	11	Gaines	☐	9/10	King	☐	01	Pecos	☐	9/10	Walker	☐	6/5S
Camp	☐	4/5N	Galveston	☐	6/5S	Kinney	☐	08	Polk	☐	4/5N	Waller	☐	6/5S
Carson	☐	01	Garza	☐	01	Kleberg	☐	11	Potter	☐	01	Ward	☐	9/10
Cass	☐	4/5N	Gillespie	☐	08	Knox	☐	2/3	Presidio	☐	9/10	Washington	☐	07
Castro	☐	01	Glasscock	☐	9/10	**-L-**			**-R-**			Webb	☐	11
Chambers	☐	6/5S	Goliad	☐	08	Lamar	☐	4/5N	Rains	☐	4/5N	Wharton	☐	6/5S
Cherokee	☐	4/5N	Gonzales	☐	08	Lamb	☐	01	Randall	☐	01	Wheeler	☐	01
Childress	☐	01	Gray	☐	01	Lampasas	☐	07	Reagan	☐	9/10	Wichita	☐	2/3
Clay	☐	2/3	Grayson	☐	2/3	La Salle	☐	08	Real	☐	08	Wilbarger	☐	2/3
Cochran	☐	01	Gregg	☐	4/5N	Lavaca	☐	08	Red River	☐	4/5N	Willacy	☐	11
Coke	☐	9/10	Grimes	☐	07	Lee	☐	07	Reeves	☐	9/10	Williamson	☐	07
Coleman	☐	2/3	Guadalupe	☐	08	Leon	☐	07	Refugio	☐	11	Wilson	☐	08
Collin	☐	2/3	**-H-**			Liberty	☐	6/5S	Roberts	☐	01	Winkler	☐	9/10
Collingsworth	☐	01	Hale	☐	01	Limestone	☐	07	Robertson	☐	07	Wise	☐	2/3
Colorado	☐	6/5S	Hall	☐	01	Lipscomb	☐	01	Rockwall	☐	2/3	Wood	☐	4/5N
Comal	☐	08	Hamilton	☐	07	Live Oak	☐	11	Runnels	☐	2/3	**-Y-**		
Comanche	☐	2/3	Hansford	☐	01	Llano	☐	07	Rusk	☐	4/5N	Yoakum	☐	01
Concho	☐	9/10	Hardeman	☐	2/3	Loving	☐	9/10	**-S-**			Young	☐	2/3
Cooke	☐	2/3	Hardin	☐	6/5S	Lubbock	☐	01	Sabine	☐	4/5N	**-Z-**		
Coryell	☐	07	Harris	☐	6/5S	Lynn	☐	01	San Augustine	☐	4/5N	Zapata	☐	11
Cottle	☐	2/3	Harrison	☐	4/5N	**-M-**			San Jacinto	☐	4/5N	Zavala	☐	08
Crane	☐	9/10	Hartley	☐	01	Madison	☐	07	San Patricio	☐	11			
Crockett	☐	9/10	Haskell	☐	2/3	Marion	☐	4/5N	San Saba	☐	07			

FORM K: CONTACT PERSON INFORMATION
TITLE V CHILD HEALTH SERVICES

Legal Business Name of Respondent: _____

This form provides information about the appropriate contacts in the Respondent's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Manager.

Executive Director:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Medical Director:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Program Coordinator:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Financial Officer:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Quality Assurance Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Public Information Contact*:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		

*Will be provided as referral information to the public by 2-1-1, the HHSC website, and other health information resources.

FORM L: CONTACT PERSON INFORMATION
TITLE V CHILD DENTAL SERVICES

Legal Business Name of Respondent: _____

This form provides information about the appropriate contacts in the Respondent's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Manager.

Executive Director:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Dental Director:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Program Coordinator:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Financial Officer:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Quality Assurance Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Public Information Contact*:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		

*Will be provided as referral information to the public by 2-1-1, the HHSC website, and other health information resources.

FORM M: SERVICE DELIVERY PLAN FOR CHILD HEALTH & CHILD DENTAL SERVICES

Legal Business Name of Respondent: _____

Respondent must describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments. Address the required elements (see SERVICE DELIVERY PLAN GUIDELINES) associated with the services proposed in this application. A maximum of **five (5)** additional pages may be attached if needed for a total of six (6) pages.

FORM M: SERVICE DELIVERY PLAN FOR CHILD HEALTH & CHILD DENTAL SERVICES
GUIDELINES

Respondent must describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments, numbering them as indicated. The service delivery plan must include a Table of Contents from Respondent's operating policies and procedures manual. The service delivery plan must:

1. Summarize the proposed **child health and/or child dental** services. Also, address if and how the Respondent will serve individuals from counties outside the stated service area.

2. Describe service delivery systems, workforce (attach organization chart), policies, support systems (i.e., training, research, technical assistance), outreach and informing, financial and administrative systems including confidential data storage, staff development (i.e., eligibility, billing, clinical training) and other infrastructure elements available to achieve service delivery and policy-making activities. What resources do you have to perform the project, who will deliver services and how will they be delivered? Describe any existing partnerships with Texas certified Community Health Workers and/or Promotoras(es) and how they are utilized in the Respondent's outreach and information efforts.

3. Describe the process of assessing client risk factors associated with family violence, substance abuse, and mental health needs.

4. Describe coordination with the other state and/or local health and human service providers in the service area(s), define how duplication of services is to be avoided, and describe the procedures in place to ensure Clients are referred to other appropriate community resources, as needed.

5. Describe ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with ADA requirements, location, hours of service delivery, and other means to ensure accessibility for the defined population).

6. If Respondent plans to subcontract any Title V reimbursable services, describe:
   - Experience subcontracting with other agencies/providers;
   - Experience performing program monitoring of subcontractors; and
   - Experience providing technical assistance to subcontractors.

7. Describe internal Quality Assurance/Quality Improvement ("QA/QI") process utilized to monitor services, identify staff responsible for ensuring that the identified processes are implemented, and who is responsible for ensuring they are updated. The description must include the following:
   - Role of the QA/QI Committee;
   - Medical and/or Dental Director's involvement in the QA/QI activities;
   - Activities utilized to identify trends of needed improvement and the frequency of those activities;
   - Activities to ensure correction and follow-up to findings identified;
   - Utilization and frequency of client satisfaction surveys;
   - System utilized to identify and monitor adverse outcomes;
   - Process for identifying performance and outcome measures; and
   - Process utilized to develop protocols and Standing Delegation Orders.

FORM N: Title V Prenatal Medical & Prenatal Dental Services

Texas Counties and Regions

COUNTIES SERVED BY PROJECT - This list is provided for item 8, **Form A: Face Page.**

Counties	☒	R	Counties	☒	R	Counties	☒	R	Counties	☒	R	Counties	☒	R
-A-			Crosby	☐	01	Hays	☐	07	Martin	☐	9/10	Schleicher	☐	9/10
Anderson	☐	4/5N	Culberson	☐	9/10	Hemphill	☐	01	Mason	☐	9/10	Scurry	☐	2/3
Andrews	☐	9/10	**-D-**			Henderson	☐	4/5N	Matagorda	☐	6/5S	Shackelford	☐	2/3
Angelina	☐	4/5N	Dallam	☐	01	Hidalgo	☐	11	Maverick	☐	08	Shelby	☐	4/5N
Aransas	☐	11	Dallas	☐	2/3	Hill	☐	07	McCulloch	☐	9/10	Sherman	☐	01
Archer	☐	2/3	Dawson	☐	9/10	Hockley	☐	01	McLennan	☐	07	Smith	☐	4/5N
Armstrong	☐	01	Deaf Smith	☐	01	Hood	☐	2/3	McMullen	☐	11	Somervell	☐	2/3
Atascosa	☐	08	Delta	☐	4/5N	Hopkins	☐	4/5N	Medina	☐	08	Starr	☐	11
Austin	☐	6/5S	Denton	☐	2/3	Houston	☐	4/5N	Menard	☐	9/10	Stephens	☐	2/3
-B-			DeWitt	☐	08	Howard	☐	9/10	Midland	☐	9/10	Sterling	☐	09
Bailey	☐	01	Dickens	☐	01	Hudspeth	☐	9/10	Milam	☐	07	Stonewall	☐	2/3
Bandera	☐	08	Dimmit	☐	08	Hunt	☐	2/3	Mills	☐	07	Sutton	☐	9/10
Bastrop	☐	07	Donley	☐	01	Hutchinson	☐	01	Mitchell	☐	2/3	Swisher	☐	01
Baylor	☐	2/3	Duval	☐	11	**-I-**			Montague	☐	2/3	**-T-**		
Bee	☐	11	**-E-**			Irion	☐	9/10	Montgomery	☐	6/5S	Tarrant	☐	2/3
Bell	☐	07	Eastland	☐	2/3	**-J-**			Moore	☐	01	Taylor	☐	2/3
Bexar	☐	08	Ector	☐	9/10	Jack	☐	2/3	Morris	☐	4/5N	Terrell	☐	9/10
Blanco	☐	07	Edwards	☐	08	Jackson	☐	08	Motley	☐	01	Terry	☐	01
Borden	☐	9/10	Ellis	☐	2/3	Jasper	☐	4/5N	**-N-**			Throckmorton	☐	2/3
Bosque	☐	07	El Paso	☐	9/10	Jeff Davis	☐	9/10	Nacogdoches	☐	4/5N	Titus	☐	4/5N
Bowie	☐	4/5N	Erath	☐	2/3	Jefferson	☐	6/5S	Navarro	☐	2/3	Tom Green	☐	9/10
Brazoria	☐	6/5S	**-F-**			Jim Hogg	☐	11	Newton	☐	4/5N	Travis	☐	07
Brazos	☐	07	Falls	☐	07	Jim Wells	☐	11	Nolan	☐	2/3	Trinity	☐	4/5N
Brewster	☐	9/10	Fannin	☐	2/3	Johnson	☐	2/3	Nueces	☐	11	Tyler	☐	4/5N
Briscoe	☐	01	Fayette	☐	07	Jones	☐	2/3	**-O-**			**-U-**		
Brooks	☐	11	Fisher	☐	2/3	**-K-**			Ochiltree	☐	01	Upshur	☐	4/5N
Brown	☐	2/3	Floyd	☐	01	Karnes	☐	08	Oldham	☐	01	Upton	☐	9/10
Burleson	☐	07	Foard	☐	2/3	Kaufman	☐	2/3	Orange	☐	6/5S	Uvalde	☐	08
Burnet	☐	07	Fort Bend	☐	6/5S	Kendall	☐	08	**-P-**			**-V-**		
-C-			Franklin	☐	4/5N	Kenedy	☐	11	Palo Pinto	☐	2/3	Val Verde	☐	08
Caldwell	☐	07	Freestone	☐	07	Kent	☐	2/3	Panola	☐	4/5N	Van Zandt	☐	4/5N
Calhoun	☐	08	Frio	☐	08	Kerr	☐	08	Parker	☐	2/3	Victoria	☐	08
Callahan	☐	2/3	**-G-**			Kimble	☐	9/10	Parmer	☐	01	**-W-**		
Cameron	☐	11	Gaines	☐	9/10	King	☐	01	Pecos	☐	9/10	Walker	☐	6/5S
Camp	☐	4/5N	Galveston	☐	6/5S	Kinney	☐	08	Polk	☐	4/5N	Waller	☐	6/5S
Carson	☐	01	Garza	☐	01	Kleberg	☐	11	Potter	☐	01	Ward	☐	9/10
Cass	☐	4/5N	Gillespie	☐	08	Knox	☐	2/3	Presidio	☐	9/10	Washington	☐	07
Castro	☐	01	Glasscock	☐	9/10	**-L-**			**-R-**			Webb	☐	11
Chambers	☐	6/5S	Goliad	☐	08	Lamar	☐	4/5N	Rains	☐	4/5N	Wharton	☐	6/5S
Cherokee	☐	4/5N	Gonzales	☐	08	Lamb	☐	01	Randall	☐	01	Wheeler	☐	01
Childress	☐	01	Gray	☐	01	Lampasas	☐	07	Reagan	☐	9/10	Wichita	☐	2/3
Clay	☐	2/3	Grayson	☐	2/3	La Salle	☐	08	Real	☐	08	Wilbarger	☐	2/3
Cochran	☐	01	Gregg	☐	4/5N	Lavaca	☐	08	Red River	☐	4/5N	Willacy	☐	11
Coke	☐	9/10	Grimes	☐	07	Lee	☐	07	Reeves	☐	9/10	Williamson	☐	07
Coleman	☐	2/3	Guadalupe	☐	08	Leon	☐	07	Refugio	☐	11	Wilson	☐	08
Collin	☐	2/3	**-H-**			Liberty	☐	6/5S	Roberts	☐	01	Winkler	☐	9/10
Collingsworth	☐	01	Hale	☐	01	Limestone	☐	07	Robertson	☐	07	Wise	☐	2/3
Colorado	☐	6/5S	Hall	☐	01	Lipscomb	☐	01	Rockwall	☐	2/3	Wood	☐	4/5N
Comal	☐	08	Hamilton	☐	07	Live Oak	☐	11	Runnels	☐	2/3	**-Y-**		
Comanche	☐	2/3	Hansford	☐	01	Llano	☐	07	Rusk	☐	4/5N	Yoakum	☐	01
Concho	☐	9/10	Hardeman	☐	2/3	Loving	☐	9/10	**-S-**			Young	☐	2/3
Cooke	☐	2/3	Hardin	☐	6/5S	Lubbock	☐	01	Sabine	☐	4/5N	**-Z-**		
Coryell	☐	07	Harris	☐	6/5S	Lynn	☐	01	San Augustine	☐	4/5N	Zapata	☐	11
Cottle	☐	2/3	Harrison	☐	4/5N	**-M-**			San Jacinto	☐	4/5N	Zavala	☐	08
Crane	☐	9/10	Hartley	☐	01	Madison	☐	07	San Patricio	☐	11			
Crockett	☐	9/10	Haskell	☐	2/3	Marion	☐	4/5N	San Saba	☐	07			

FORM O: CONTACT PERSON INFORMATION
TITLE V PRENATAL MEDICAL SERVICES

Legal Business Name of Respondent: _____

This form provides information about the appropriate contacts in the Respondent's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Manager.

Executive Director:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Medical Director:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Program Coordinator:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Financial Officer:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Quality Assurance Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Public Information Contact*:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		

*Will be provided as referral information to the public by 2-1-1, the HHSC website, and other health information resources.

FORM P: CONTACT PERSON INFORMATION
TITLE V PRENATAL DENTAL SERVICES

Legal Business Name of Respondent: _____

This form provides information about the appropriate contacts in the Respondent's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Manager.

Executive Director:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Dental Director:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Program Coordinator:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Financial Officer:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Quality Assurance Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		
Public Information Contact*:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:		
Fax:		
E-mail:		

FORM Q: SERVICE DELIVERY PLAN FOR PRENATAL MEDICAL & PRENATAL DENTAL SERVICES

Legal Business Name of Respondent: _____

Respondent must describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments. Address the required elements (see SERVICE DELIVERY PLAN GUIDELINES) associated with the services proposed in this application. A maximum of **five (5)** additional pages may be attached if needed for a total of six (6) pages.

FORM Q: SERVICE DELIVERY PLAN FOR PRENATAL MEDICAL & PRENATAL DENTAL SERVICES GUIDELINES

Respondent must describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments, numbering them as indicated. The service delivery plan must include a Table of Contents from Respondent's operating and procedures manual. The service delivery plan must:

1. Summarize the proposed **prenatal medical and/or prenatal dental** services and how Respondent will assist patient with the CHIP Perinatal Program application process. Also, address if and how the Respondent will serve individuals from counties outside the stated service area.

2. Describe delivery systems, workforce (attach organizational chart), policies, support systems (i.e., training, research, technical assistance), outreach and informing, financial and administrative systems including confidential data storage, staff development (i.e., eligibility, billing, clinical training) and other infrastructure elements available to achieve service delivery and policy-making activities. What resources do you have to perform the project, who will deliver services and how will they be delivered? Describe any existing partnerships with Texas certified Community Health Workers and/or Promotoras(es) and how they are utilized in the Respondent's outreach and information efforts.

3. Describe process of assessing risk factors associated with family violence, substance abuse and mental health needs.

4. Describe coordination with the other state and/or local health and human service providers in the service area(s), define how duplication of services is to be avoided, and describe the procedures in place to ensure Clients are referred to other appropriate community resources, as needed.

5. Describe ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with ADA requirements, location, hours of service delivery, and other means to ensure accessibility for the defined population).

6. If Respondent plans to subcontract out any Title V reimbursable services, describe:
   - Experience subcontracting with other agencies/providers;
   - Experience performing program monitoring of subcontractors; and
   - Experience providing technical assistance to subcontractors.

7. Describe internal Quality Assurance/Quality Improvement ("QA/QI") process utilized to monitor services, identify staff responsible for ensuring that the identified processes are implemented, and who is responsible for ensuring they are updated. The description must include the following:
   - Role of the QA/QI Committee;
   - Medical and/or Dental Director's involvement in the QA/QI activities;

- Activities utilized to identify trends of needed improvement and the frequency of those activities;
- Activities to ensure correction and follow-up to findings identified;
- Utilization and frequency of client satisfaction surveys;
- System utilized to identify and monitor adverse outcomes;
- Process for identifying performance and outcome measures; and
- Process utilized to develop protocols and Standing Delegation Orders

FORM R-1: TITLE V CHILD HEALTH & CHILD DENTAL CEILING REQUEST and PERFORMANCE MEASURES

Legal Business Name of Respondent: _____

This page should reflect all services projected to be delivered during the contract period for those services categories described in your Service Delivery Plan and for which you intend to bill and expect to be paid (See **Form R-1: Title V Child Health and Dental Ceiling Request and Performance Measures Guidelines**).

If you provide services in counties located in different HHSC regions, complete a separate form for each HHSC Region. Do not complete a form for each county.

FY20 PROJECTED
Estimated Number of Unduplicated Clients

HSR: ☐1 ☐2/3 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11	Infants 0-11 months Children & Adolescents 1-21 years	
	Number of Clients*	Total $ Amount for all services provided
Child Health (include costs for laboratory and case management)		$
Child Dental		$
GRAND TOTAL** Number of Clients and Dollars Requested		
Title V Case Management for Children and Pregnant Woman ("TV CPW")	Currently a provider and interested in continuing: ☐ Yes ☐ No	Not currently a provider, but am interested in applying: ☐ Yes ☐ No

***Note to contractors, the projected Number of Unduplicated Clients is subject to change depending on funding provided.**

****Grand Total amount must match amount requested on Form A: Face Page, #9.**

FORM R-1: TITLE V CHILD HEALTH AND CHILD DENTAL CEILING REQUEST AND PERFORMANCE MEASURES GUIDELINES

FORM R-1 must be used for Title V proposed child health and dental services only. The form reflects the estimated unduplicated number of the Title V child health and/or child dental eligible Clients the Respondent proposes to serve, and the total amount estimated to be billed to the Title V Child Health & Child Dental Services program. Complete a separate FORM R-1 for each Health Service Region in which services will be provided.

Steps to complete form:

1. Identify the Health Service Region ("HSR") in the first column, row 1.

2. For Child Health, enter the projected number of unduplicated Clients to be served and the corresponding dollar amounts.

3. For Child Dental enter the projected number of unduplicated Clients to be served and the corresponding dollar amounts.

4. Enter the Grand Total number of Clients and total dollar amount (rounded to the nearest dollar). The Grand Total must equal the amount of funding requested for Title V Child Health & Child Dental Services on **FORM A: FACE PAGE, #9.**

5. Concerning Title V Case Management for Children and Pregnant Women ("Title V CPW"), indicate if the Respondent is a current provider and wants to continue to provide Title V CPW services by checking “Yes” or “No". If the Respondent is not a current provider, check “Yes” or “No” if interested in applying to be a provider. **Note:** A contractor cannot bill Title V for case management codes G9012-U5-U2, G9012-U5-TS, or G9012-TS if not registered as a Title V CPW provider.

See Attachment A: Title V Services and Reimbursement Rates on page 69 of the solicitation.

FORM R-2: TITLE V PRENATAL MEDICAL & PRENATAL DENTAL CEILING REQUEST and PERFORMANCE MEASURES

Legal Business Name of Respondent: _____

This page should reflect all services projected to be delivered during the contract period for those services categories described in your Service Delivery Plan and for which you intend to bill and expect to be paid (See **Form R-2: Title V Prenatal Medical & Prenatal Dental Ceiling Request and Performance Measures Guidelines**).

If you provide services in counties located in different HHSC regions, complete a separate form for each HHSC Region. Do not complete a form for each county.

FY20 PROJECTED
Estimated Number of Unduplicated Clients

HSR: ☐1 ☐2/3 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11	Pregnant Women	
	Number of Clients*	Total $ Amount for all services provided
Prenatal Medical (include costs for laboratory and case management)		$
Prenatal Dental		$
GRAND TOTAL** Number of Clients and Dollars Requested		
Title V Case Management for Children and Pregnant Woman ("TV CPW")	Currently a provider and interested in continuing: ☐ Yes ☐ No	Not currently a provider, but am interested in applying: ☐ Yes ☐ No

***Note to contractors, the projected Number of Unduplicated Clients is subject to change depending on funding provided.**

****Grand Total amount must match amount requested on Form A: Face Page, #9.**

FORM R-2: TITLE V PRENATAL MEDICAL AND PRENATAL DENTAL CEILING REQUEST AND PERFORMANCE MEASURES GUIDELINES

FORM R-2 must be used for Title V proposed prenatal medical and prenatal dental services only. The form reflects the estimated unduplicated number of Title V prenatal medical and/or prenatal dental eligible Clients the Respondent proposes to serve and the total amount estimated to be billed to the Title V Prenatal Medical Services program. Complete a separate FORM R-2 for each Health Service Region ("HSR") in which services will be provided.

Steps to complete form:

1. Identify the Health Service Region ("HSR") in the first column, row 1.

2. For Prenatal Medical services, enter the projected number of unduplicated Clients to be served and the corresponding dollar amounts.

3. For Prenatal Dental service enter the projected number of unduplicated Clients to be served and the corresponding dollar amounts.

4. Enter the Grand Total number of Clients and total dollar amount (rounded to the nearest dollar). The Grand Total must equal the amount of funding requested for Title V Prenatal Medical & Prenatal Dental Services on **FORM A: FACE PAGE, #9**.

5. Concerning Title V Case Management for Children and Pregnant Women ("Title V CPW"), indicate if the Respondent is a current provider and wants to continue to provide Title V CPW services by checking "Yes" or "No". If the Respondent is not a current provider, check "Yes" or "No" if interested in applying to be a provider. **Note:** A contractor cannot bill Title V for case management codes G9012-U5-U2, G9012-U5-TS, or G9012-TS if not registered as a Title V CPW provider.

See Attachment A: Title V Services and Reimbursement Rates on page 69 of the solicitation.

FORM S: Title V Subcontractor Information

Complete a separate Title V Subcontractor Information Form for each subcontractor. Please provide the following information on the subcontractor(s) that provide direct services to HHSC Title V Clients. A subcontractor is one who does all or part of the work required in the original contract. The contractor would reimburse the subcontractor for the services provided with the reimbursement rate or agreed amount.

This form is not applicable because we do not subcontract Title V services.
☐

Subcontractor Name:
Contactor Name:
Subcontractor's Physical Address: (include street, city, county, state, Zip)
Subcontractor's Mailing Address: (include street, city, county, state, Zip)
Phone:
Fax:
Contact Email:

ATTACHMENT A: TITLE V SERVICES AND REIMBURSEMENT RATES

Excel worksheets are provided that show the Title V Services and Reimbursement Rates for each of the funding sources in the application.

These worksheets are posted at http://www.dshs.state.tx.us/chscontracts/default.shtm.

These Title V rate worksheets are included for informational purposes in order to assist Respondents in completing **Form R-1: Title V Child Health & Child Dental Ceiling Request and Performance Measures** and **Form R-2: Title V Prenatal Medical & Prenatal Dental Ceiling Request and Performance Measures**.

The worksheet should not be returned with the application response.