FORM A | ADMINISTRATIVE PACKET

Instructions: This workbook contains six tabs, each with different administrative elements specified within the Request for Applications. Please respond to information shaded in yellow on each of the tabs below. Cells shaded green will pre-fill from other areas on your form. Blue indicates cell is complete.

LEAD APPLICANT AND ORGANIZATION INFORMATION	
Legal Name	
Mailing Address	
Street Address	
City	
County	
Zip (9-digit)	
Physical Address (If different from Mailing Address)	
Street Address	
City	
County	
Zip (9-digit)	
Payee Name and Address (If different from Mailing & Physical Address)	
Street Address	
City	
County	
Zip (9-digit)	
DUNS Number	
Federal Tax ID Number	

TYPE OF ENTITY	
Click drop down menu for options:	If "Other", describe:

CONTACT INFORMATION	
Program Contact Person	
Name	
Phone	
Fax	
E-mail	
Financial Officer	
Name	
Phone	
Fax	
E-mail	

Authorizing Official

The facts affirmed by me in this proposal are truthful and I warrant the respondent is in compliance with RFA terms and conditions, including HHSC's Uniform Contract Terms and Conditions, and other RFA requirements unless specifically noted on the Respondent Information and Disclosure Form. 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.

Name	
Title	
Phone	
Fax	
E-mail	
Authorizing Official Signature	
Date	

Legal Business Name of Respondent:	0

COUNTIES PROPOSED TO BE SERVED

For each county proposed to be served, please select "YES" in the Served column. For counties not served, leave column blank

AGENCY NAME	REGION	COUNTY	CLIENTS TO BE SERVED
0	4	Anderson	
0	9	Andrews	
0	5	Angelina	
0	11	Aransas	
0	2	Archer	
0	1	Armstrong	
0	8	Atascosa	
0	6	Austin	
0	1	Bailey	
0	8	Bandera	
0	7	Bastrop	
0	2	Baylor	
0	11	Bee	
0	7	Bell	
0	8	Bexar	
0	7	Blanco	
0	9	Borden	
0	7	Bosque	
0	4	Bowie	
0	6	Brazoria	
0	7	Brazos	
0	10	Brewster	
0	1	Briscoe	
0	11	Brooks	
0	2	Brown	
0	7	Burleson	
0	7	Burnet	
0	7	Caldwell	
0	8	Calhoun	
0	2	Callahan	
0	11	Cameron	
0	4	Camp	
0	1	Carson	
0	4	Cass	
0	1	Castro	
0	6	Chambers	
0	4	Cherokee	
0	1	Childress	
0	2	Clay	
0	1	Cochran	
0	9	Coke	
0	2	Coleman	
0	3	Collin	
0	1	Collingsworth	
0	6	Colorado	
0	8	Comal	
0	2	Comanche	
0	9	Concho	
0	3	Cooke	
0	7	Coryell	
0	2	Cottle	

0	9	Crane	
0	9	Crockett	
0	1	Crosby	
0	10	Culberson	
0	1	Dallam	
0	3	Dallas	
0	9	Dawson	
0	1	Deaf Smith	
0	4	Delta	
0	3	Denton	
0	8	DeWitt	
0	1	Dickens	
0	8	Dimmit	
0	1	Donley	
0	11	Duval	
0	2	Eastland	
0	9	Ector	
0	8	Edwards	
0	10	El Paso	
0	3	Ellis	
0	3	Erath	
0	7	Falls	
0	3	Fannin	
0	7	Fayette	
0	2	Fisher	
0	1	Floyd	
0	2	Foard	
0	6	Fort Bend	
0	4	Franklin	
0	7	Freestone	
0	8	Frio	
0	9	Gaines	
0	6	Galveston	
0	1	Garza	
0	8	Gillespie	
0	9	Glasscock	
0	8	Goliad	
0	8	Gonzales	
0	1	Gray	
0	3	Grayson	
0	4	Gregg	
0	7	Grimes	
0	8	Guadalupe	
0	1	Hale	
0	1	Hall	
0	7	Hamilton	
0	1	Hansford	
0	2	Hardeman	
0	5	Hardin	
0	6	Harris	
0	4	Harrison	
0	1	Hartley	
0	2	Haskell	
0	7	Hays	
0	1	Hemphill	
0	4	Henderson	
0	11	Hidalgo	

0	7	Hill	
0	1	Hockley	
0	3	Hood	
0	4	Hopkins	
0	5	Houston	
0	9	Howard	
0	10	Hudspeth	
0	3	Hunt	
0	1	Hutchinson	
0	9	Irion	
0	2	Jack	
0	8	Jackson	
0	5	Jasper	
0	10	Jeff Davis	
0	5	Jefferson	
0	11	Jim Hogg	
0	11	Jim Wells	
0	3	Johnson	
0	2	Jones	
0	8	Karnes	
0	3	Kaufman	
0	8	Kendall	
0	11	Kenedy	
0	2	Kent	
0	8	Kerr	
0	9	Kimble	
0	1	King	
0	8	Kinney	
0	11	Kleberg	
0	2	Knox	
0	4	Lamar	
0	1	Lamb	
0	7	Lampasas	
0	8	LaSalle	
0	8	Lavaca	
0	7	Lee	
0	7	Leon	
0	6	Liberty	
0	7	Limestone	
0	1	Lipscomb	
0	11	Live Oak	
0	7	Llano	
0	9	Loving	
0	1	Lubbock	
0	1	Lynn	
0	7	Madison	
0	4	Marion	
0	9	Martin	
0	9	Mason	
0	6	Matagorda	
0	8	Maverick	
0	9	McCulloch	
0	7	McLennan	
0	11	McMullen	
0	8	Medina	
0	9	Menard	
0	9	Midland	

0	7	Milam	
0	7	Mills	
0	2	Mitchell	
0	2	Montague	
0	6	Montgomery	
0	1	Moore	
0	4	Morris	
0	1	Motley	
0	5	Nacogdoches	
0	3	Navarro	
0	5	Newton	
0	2	Nolan	
0	11	Nueces	
0	1	Ochiltree	
0	1	Oldham	
0	5	Orange	
0	3	Palo Pinto	
0	4	Panola	
0	3	Parker	
0	1	Parmer	
0	9	Pecos	
0	5	Polk	
0	1	Potter	
0	10	Presidio	
0	4	Rains	
0	1	Randall	
0	9	Reagan	
0	8	Real	
0	4	Red River	
0	9	Reeves	
0	11	Refugio	
0	1	Roberts	
0	7	Robertson	
0	3	Rockwall	
0	2	Runnels	
0	4	Rusk	
0	5	Sabine	
0	5	San Augustine	
0	5	San Jacinto	
0	11	San Patricio	
0	7	San Saba	
0	9	Schleicher	
0	2	Scurry	
0	2	Shackelford	
0	5	Shelby	
0	1	Sherman	
0	4	Smith	
0	3	Somervell	
0	11	Starr	
0	2	Stephens	
0	9	Sterling	
0	2	Stonewall	
0	9	Sutton	
0	1	Swisher	
0	3	Tarrant	
0	2	Taylor	
0	9	Terrell	

0	1	Terry	
0	2	Throckmorton	
0	4	Titus	
0	9	Tom Green	
0	7	Travis	
0	5	Trinity	
0	5	Tyler	
0	4	Upshur	
0	9	Upton	
0	8	Uvalde	
0	8	Val Verde	
0	4	Van Zandt	
0	8	Victoria	
0	6	Walker	
0	6	Waller	
0	9	Ward	
0	7	Washington	
0	11	Webb	
0	6	Wharton	
0	1	Wheeler	
0	2	Wichita	
0	2	Wilbarger	
0	11	Willacy	
0	7	Williamson	
0	8	Wilson	
0	9	Winkler	
0	3	Wise	
0	4	Wood	
0	1	Yoakum	
0	2	Young	
0	11	Zapata	
0	8	Zavala	

Legal Business Name of Respondent:		0

PROPOSED COVERED SERVICES

For each service to be provided, please select "X" in column B. For services not to be provided, leave blank.

REQUIRED SUPPLY/ SERVICES	MARK X IF YES	PROVIDED ONSITE	PROVIDED THROUGH REFERRAL	CLIENTS TO BE SERVED
Breast Diagnostics				
Cervical Diagnostics				
Cervical Dysplasia Treatment				
Cervical Screening			NOT APPLICABLE	
Cholesterol Screening			NOT APPLICABLE	
Client Education/Counseling			NOT APPLICABLE	
Clinical Breast Examination (CBE)			NOT APPLICABLE	
Diabetes Screening			NOT APPLICABLE	
Eligibility Determination			NOT APPLICABLE	
Health Promotion/Disease Prevention			NOT APPLICABLE	
HIV Testing			NOT APPLICABLE	
Hypertension Screening				
Immunizations				
Informed Consent			NOT APPLICABLE	
Laboratory Services				
Level I Infertility Services			NOT APPLICABLE	
Limited Postpartum Depression Screening				
Limited Prenatal Services				
Mammography				
Medical History			NOT APPLICABLE	
Minor GYN Problems			NOT APPLICABLE	
Natural Family Planning Instruction			NOT APPLICABLE	
Pap Test			NOT APPLICABLE	
Physical Examination			NOT APPLICABLE	
Pregnancy Diagnosis/Counseling			NOT APPLICABLE	
Special GYN Procedures			NOT APPLICABLE	
STI Testing and Treatment			NOT APPLICABLE	
REQUIRED CONTRACEPTIVE SUPPLY/ SERVICES				
Male sterilization			NOT APPLICABLE	
Intrauterine Contraceptive Device (IUD/ IUS)			NOT APPLICABLE	
Hormonal Implant (Nexplanon™)				
edroxyprogesterone Acetate IM Injection (DMPA/Depo)				
Oral Contraceptives				
Transdermal Hormonal Contraceptive (Patch)*			NOT APPLICABLE	
Vaginal Hormonal Contraceptive (Ring)*			NOT APPLICABLE	
Male Condom			NOT APPLICABLE	
Female Condom			NOT APPLICABLE	
Contraceptive Sponge			NOT APPLICABLE	
Female Condoms			NOT APPLICABLE	
Spermicidal Methods or Products			NOT APPLICABLE	
Abstinence Education			NOT APPLICABLE	

Legal Business Name of Respondent:	0

CONTACT INFORMATION

Please complete the following form as follows:

• **NON-PROFIT RESPONDENT** | Include the below information for members of the Board of Directors.

• **GOVERNMENTAL ENTITY** | Include the below information for the officials who are authorized to enter into a contract on behalf of respondent.

• **NON-GOVERNMENTAL ENTITY** | Include the below information for the officials who are authorized to enter into a contract on behalf of respondent.

Please attach multiple sheets if needed.

Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	
Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	
Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	
Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	
Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	
Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	
Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	
Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	

Name		Street	
Title		City	
Phone		County	
Fax		State	
Email		Zip	

Legal Business Name of Respondent:	0

AGENCY INFORMATION AND LITIGATION HISTORY

This form provides information regarding identification and contract history of the Applicant, executive management, project management, governing board members and/or principal officers. If responses require multiple pages, label the supporting pages by referencing the form and question number. Administrative Information may be used in screening and/or evaluating proposals.

NON-PROFIT DETERMINATION

1. Is Applicant a nonprofit organization? (If YES, Applicant must attach evidence of nonprofit status using one of the methods below).	
2. Any one of the following is acceptable evidence of non-profit status. Use the dropdown list to indicate item(s) submitted	
A copy of a current, valid IRS exemption certificate.	
A statement from a State taxing body, State Attorney General, or other appropriate State official certifying the Applicant organization has a nonprofit status and no net earnings accrue to any private shareholders or individuals.	
A copy of the Applicant organization's certificate of formation or similar document clearly establishing the Applicant organization's nonprofit status.	
Any of the above proof for a State or national parent organization **and** a statement signed by the parent organization that the Applicant organization is a local nonprofit affiliate.	

CONFLICT OF INTEREST AND LITIGATION HISTORY

The Applicant must disclose any existing or potential conflict of interest relative to performance of the requirements of this RFA. Examples of potential conflicts include an existing or potential business or personal relationship between the Applicant, its principal, or any affiliate or subcontractor, with the Health and Human Services Commission, the Program Administrator or any other entity or person involved in any way in any project that is the subject of this RFA. The Applicant must disclose any such relationship that might be perceived or represented as a conflict. Failure to do so may be cause for contract termination or proposal disqualification. If, following a review of this information, HHSC determines a conflict of interest exists, the Applicant may be disqualified from further consideration for the award of a contract.

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

3. Does anyone in the Applicant organization have an existing or potential conflict of interest relative to performing requirements of this RFA? If YES, detail any such relationship(s) that might be perceived or represented as a conflict below. (You may attach no more than one additional page.)	
4. Will any person who received compensation from Health and Human Services Commission (HHSC) for participating in preparing specifications or documentation for this RFA participate financially with Applicant as a result of an award under this RFA? 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 may result from this RFA constitute an actual or potential conflict of interest or create the appearance of impropriety? If YES, detail any such actual or potential conflict of interest that might be perceived or represented as a conflict. (You may attach no more than one additional page.)	
6. Are any current or former employees of the Applicant current or former employees of HHSC (within the last 24 months)? If YES, indicate his/her name, job title, agency employed by, separation date, and reason for separation.	
7. Are any proposed personnel related to any current or former employees of HHSC? If YES, indicate his/her name, job title, agency employed by, separation date, and reason for separation.	
8. Has any member of Applicant's executive management, project management, governing board or principal officers been employed by HHSC 24 months prior to the proposal submission date? If YES, indicate his/her name, job title, agency employed by, separation date, and reason for separation.	
9. If the Applicant is a private nonprofit organization, does the executive director or other staff serve as voting members on the organization's governing board? If YES, provide names and job titles of all staff who serve as voting members on the board.	
10. Is Applicant or any member of Applicant's executive management, project management, board members or principal officers: (Select yes if any are applicable) • 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? If YES, please explain. (Attach no more than one additional page.)	
11. Has the Applicant: • Had a contract suspended or terminated prior to contract expiration, or • Not been renewed under an optional renewal by any local, state, or federal department or agency or non-profit entity? **If YES, indicate reason for each action include:** • Name and contact information of the local, state, or federal department or agency • Date of the contract and a contract reference number, and • Copies of any and all decisions or orders related to suspension, termination or non-renewal by the contracting entity.	

12. Does this proposal include financial participation by a person or entity that has been: • Convicted of violating federal law, or • 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 2261.053? If YES, please explain. (Attach no more than one additional page.)	
13. Has respondent had a contract with HHSC within the past 24 months, including former business structures? If yes, list the HHSC program name and contract numbers.	

Legal Business Name of Respondent:	**0**

Required Attachments - Please attach the following documents to this form as part of the Response Package.
1. Finanical statements for the most recently completed fiscal year or a period of 12 months; and
2. Most recently audited financial report (within the past two years) including all supplements, management discussions and analysis, acutuarial opinions, and other documents as applicable.

FINANCIAL MANAGEMENT & ADMINISTRATIION QUESTIONAIRE

The type of Accounting system often depends on the size of the organization. Briefly describe the respondent's Accounting system including the following questions.

ACCOUNTING SYSTEM

a) Is the accounting system computerized, manual, or a combination of both	
b) How are different types of transactions (e.g. cash disbursements, cash receipts, revenues, journal entries) recorded and posted to the general ledger?	
c) When does your organization close your general ledger (e.g., monthly by the 10th of the following month)	

Answer each of the following questions with either a "yes" or "no" selecting from the drop-down box. Additional information may be provided in the text area below the question, if the response is "yes". **If "no" is marked, an explanation must be provided.**

1. Is your accounting system organized to allow an auditor to trace financial report balances through the general ledger and other summary ledgers/journals to each detail accenting transaction and supporting source documentation?	
2. Does your accounting system have the capability of identifying the receipt and expenditures of program funds and program income separately for each HHSC Contract/Program Attachment?	
3. Does your accounting system provide for the recording of expenditures for each HHSC Contract/Program Attachment by the budget cost categories shown in the proposed budget?	
4. Does your accounting system provide for the segregation of direct and indirect expenses and the allocation of indirect costs?	
5. Are time records (e.g., time sheets) maintained for all employees where their actual time/effort is recorded and specifically identified to a particular cost objective?	

6. Is the employees' time/effort that is recorded on the time record the source/basis of the calculation of salary/wage costs recorded in the general ledger for each cost objective?	
GENERAL ADMINISTRATION & INTERNAL CONTROLS	
1. Is the staff who will be responsible for the financial management of the award generally familiar with the existing regulations and guidelines containing the cost principles and financial administrative requirements applicable to state and federal contracts/grants?	
2. Does your organization have written Accounting policies and procedures, including use of TMHP and/ or MED-IT?	
3. Are generally accepted accounting principles followed for separation of duties regarding receipts and deposit of funds and payment of goods and services?	
4. Are procedures in place with adequate controls to ensure that receipts and disbursements are authorized and appropriately documented?	
5. Are all disbursements approved prior to payment?	
6. Is there any additional review or special approval required for checks exceeding a specific dollar amount?	
7. Are there written procedures and internal controls established for the procurement of goods and services?	
8. Do purchase orders/requisitions require specific approvals from authorized individuals in the requesting department?	
9. Are supporting documents (invoices, receipts, approvals, receiving reports, canceled checks, etc.) maintained for each disbursement and on file for easy location and retrieval?	

10. Do supporting documents accompany checks for the check signer's signature?	
11. Are supporting documents marked when paid to prevent reuse or duplication of payment?	
12. Are invoices coded to identify allocation of payment by cost objective and sub-account?	
13. Does your organization stay current with payments of its accounts payable, payroll taxes and other liabilities, loans, taxes, etc.?	
14. As program income is to be used for program purposes, are there procedures and controls to ensure proper use, accountability, and allocation?	
15. Do you have written personnel policies?	
16. Does your policy require individual daily time and attendance records for personnel (part-time, full-time, and/or in-kind volunteers)?	
17. Do procedures ensure that time and attendance reports can be specifically traced to costs recorded in the general ledger for each payroll period for each cost objective?	
18. Do you have written job descriptions with set salary levels for each employee?	
19. Do you have on file authorizations covering rates of pay, withholding and deductions for each employee?	

The Financial Management and Administration Questionnaire must be signed by an authorized person who has either completed or reviewed the form and can attest to the accuracy of the information provided.			
Authorizing Official Name and Title:			
Signature:		**Date:**	

Legal Business Name of Respondent:	**0**
Clinic #1	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #2	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #3	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #4	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #5	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	

Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #1	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	
EXECUTIVE SUMMARY	

Clinic #6	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #7	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #8	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #9

Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Clinic #10	
Clinic Name	
Full Address of Clinic Location	
Clinic Phone Number	
Medicaid TPI and NPI	
TPI Number	
NPI Number	
Proposed Clients to be Served	
Unduplicated Clients to be Served per Month	
Unduplicated Clients to be Served per Year	

Note: Please add all clinics under this contract.

Legal Business Name of Respondent:	**0**
Project Name	
BUDGET SUMMARY	
State Funds Requested	
Matching Funds Required for BCCS	
TOTAL PROJECT BUDGET	**$0.00**
LEGISLATIVE DISTRICTS	
House District	
Senate District	
EXECUTIVE SUMMARY	