

FORM A: Face Page

Department of State Health Services Consumer Protection Program

This form requests basic information about the respondent and project, including the signature of the authorized representative.

RESPONDENT INFORMATION																			
1) LEGAL NAME: Tarrant County																			
2) MAILING Address Information (include mailing address, street, city, county, state and 9-digit zip code): 1101 S. Main St., Suite 1700 Fort Worth TX, 76106-4802																			
3) PAYEE Mailing Address, including 9-digit zip code (if different from above): Tarrant County Public Health - 537-18-0113-00001 100 E. Weatherford St., Room 506 Fort Worth, TX 79196-0103																			
4) Federal Tax ID No. (9-digit), State of Texas Comptroller Vendor ID No. (14-digit) or if 75-6001170 , 17560011706006 an individual, Social Security Number (9-digit) : *The vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.																			
5) TYPE OF ENTITY (check all that apply): <table border="0"><tr><td><input type="checkbox"/> City</td><td><input type="checkbox"/> Nonprofit Organization*</td><td><input type="checkbox"/> Individual</td></tr><tr><td><input checked="" type="checkbox"/> County</td><td><input type="checkbox"/> For Profit Organization*</td><td><input type="checkbox"/> FQHC</td></tr><tr><td><input type="checkbox"/> Other Political Subdivision</td><td><input type="checkbox"/> HUB Certified</td><td><input type="checkbox"/> State Controlled Institution of Higher Learning</td></tr><tr><td><input type="checkbox"/> State Agency</td><td><input type="checkbox"/> Community-Based Organization</td><td><input type="checkbox"/> Hospital</td></tr><tr><td><input type="checkbox"/> Indian Tribe</td><td><input type="checkbox"/> Minority Organization</td><td><input type="checkbox"/> Private</td></tr><tr><td></td><td><input type="checkbox"/> Faith-based Organization</td><td><input type="checkbox"/> Other (specify): _____</td></tr></table> *If incorporated, provide 10-digit charter number assigned by Secretary of State:		<input type="checkbox"/> City	<input type="checkbox"/> Nonprofit Organization*	<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> County	<input type="checkbox"/> For Profit Organization*	<input type="checkbox"/> FQHC	<input type="checkbox"/> Other Political Subdivision	<input type="checkbox"/> HUB Certified	<input type="checkbox"/> State Controlled Institution of Higher Learning	<input type="checkbox"/> State Agency	<input type="checkbox"/> Community-Based Organization	<input type="checkbox"/> Hospital	<input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Minority Organization	<input type="checkbox"/> Private		<input type="checkbox"/> Faith-based Organization	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> City	<input type="checkbox"/> Nonprofit Organization*	<input type="checkbox"/> Individual																	
<input checked="" type="checkbox"/> County	<input type="checkbox"/> For Profit Organization*	<input type="checkbox"/> FQHC																	
<input type="checkbox"/> Other Political Subdivision	<input type="checkbox"/> HUB Certified	<input type="checkbox"/> State Controlled Institution of Higher Learning																	
<input type="checkbox"/> State Agency	<input type="checkbox"/> Community-Based Organization	<input type="checkbox"/> Hospital																	
<input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Minority Organization	<input type="checkbox"/> Private																	
	<input type="checkbox"/> Faith-based Organization	<input type="checkbox"/> Other (specify): _____																	
6) COUNTIES SERVED BY PROJECT: Tarrant County (Texas Public Health Region 2/3, Arlington, submitting samples from the North Texas Region)																			
7) PROJECT CONTACT PERSON																			
Name: Rune-Par Nilsson Phone: 817-321-4757 Fax: 817-321-4790 E-mail: rinilsson@tarrantcountytx.gov																			
The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications attached in Appendix A, and will provide services in accordance with 25 Texas Administrative Code, §37.51-37.65 . This document has been duly authorized by the governing body of the applicant and I (the person signing below) am authorized to represent the applicant.																			
8) AUTHORIZED REPRESENTATIVE Name: Tim O'Hare Title: County Judge Phone: 817-884-1441 Fax: E-mail: countyjudgegrants@tarrantcountytx.gov	9) SIGNATURE OF AUTHORIZED REPRESENTATIVE 10) DATE																		

GENERAL INSTRUCTIONS FOR THE FACE PAGE

This form provides basic information about the applicant and the proposed project with the Department of State Health Services (DSHS), including the signature of the authorized representative. It is the cover page of the application and is required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the contract 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 applicant's application.

- 1) **LEGAL NAME** - Enter the legal name of the applicant.
- 2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and 9-digit zip code.
- 3) **PAYEE MAILING ADDRESS** - Payee – Entity involved in a contractual relationship with applicant to receive payment for services rendered by applicant and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address, including 9-digit zip code, if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.
- 4) **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 vendor acknowledges, understands and agrees that the vendor's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.
- 5) **TYPE OF ENTITY** - 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 Texas Building and Procurement Commission 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.
- 6) **COUNTIES SERVED BY PROJECT** - Enter the proposed region and/or counties served by the project.
- 7) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.
- 8) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and e-mail address of the person authorized to represent the applicant. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.
- 9) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant must sign in this blank.
- 10) **DATE** - Enter the date the authorized representative signed this form.

01252024

APPROVED AS TO FORM:

Kimberly Colliet Wesley
Criminal District Attorney's Office*

*By law, the Criminal District Attorney's Office may only approve contracts for its clients. We reviewed this document as to form from our client's legal perspective. Other parties may not rely on this approval. Instead those parties should seek contract review from independent counsel.