



FY 22/23 Request for Local Public Health Services Funds (LPHS)

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**Contract documents are due to DSHS on or before
February 18, 2021 by COB @ via email to**

LocalPHTeam@dshs.texas.gov

Please reference your entity's name in the subject line of your email.

(Example: [Entity's Name], FY22/23 RLSS/LPHS)

Please contact your contract manager at (512) 776-2181 for assistance in completing the
FY22/23 RLSS/LPHS contract documents.



FY 22/23 Local Public Health Services

FORM A - FACE PAGE

RESPONDENT INFORMATION	
1) LEGAL NAME: COLLIN COUNTY HEALTH CARE SERVICES	
2) MAILING Address Information (include mailing address, street, city, county, state and zip code): Collin County Health Care Services 825 N. McDonald, Suite 130 McKinney, Texas 75069	
3) PAYEE Mailing Address (if different from above): Collin County Auditor's Office 2300 Bloomdale Road, Suite 3100 McKinney, Texas 75071	
4) Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or if an individual, Social Security Number (9 digit) : 756000873 <small>*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.</small>	
5) TYPE OF ENTITY (check all that apply):	
<input type="checkbox"/> City <input checked="" type="checkbox"/> Regions/Counties/LHD <input type="checkbox"/> Other Political Subdivision <input type="checkbox"/> State Agency <input type="checkbox"/> Indian Tribe	<input type="checkbox"/> Nonprofit Organization* <input type="checkbox"/> For Profit Organization* <input type="checkbox"/> HUB Certified <input type="checkbox"/> Community-Based Organization <input type="checkbox"/> Minority Organization <input type="checkbox"/> Faith-based Organization
<input type="checkbox"/> Individual <input type="checkbox"/> FQHC <input type="checkbox"/> State Controlled Institution of Higher Learning <input type="checkbox"/> Hospital <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): _____	
<small>*If incorporated, provide 10-digit charter number assigned by Secretary of State:</small>	
6) COUNTIES OR REGION SERVED BY PROJECT: COLLIN See attached County/Region list.	
7) PROJECT CONTACT PERSON	CHECK FUNDING APPLYING FOR:
Name: Sam Grader Phone: 972-548-5503 Fax: 972-548-4441 E-mail: sgrader@co.collin.tx.us	<input type="checkbox"/> LPHS \$43,278
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 FORM E, 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 (Person authorized to sign Contract)	9) DATE
Name: Chris Hill Title: County Judge Phone: 972-548-4635 Fax: 972-548-4699 E-mail: chill@co.collin.tx.us	

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 name of the authorized representative. It is the cover page of the proposal and is required to be completed. **DSHS Assurances and Certifications** 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 proposal.

- 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 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 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 counties or region to be 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 and authorized to sign contract. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.
- 9) **DATE** - Enter the date this form is completed.



FY 22/23 Local Public Health Services

Division for Regional and Local Health Operations

Program Contact Information

Contract Term: September 1, 2021 through August 31, 2023

Legal Name of Applicant:

COLLIN COUNTY HEALTH CAER SERVICES

This form provides information about appropriate program contacts in the applicant's organization. If any of the contact information changes during the term of the contract, please send written notification to the Regional and Local Health Service & Compliance Branch, Mail Code 1990, P.O. Box 149347, Austin, TX 78714 or email to LocalPHTeam@dshs.state.tx.us.

Director section with contact and mailing address details for Candy Blair.

Financial Manager section with contact and mailing address details for Janna Benson-Caponera.

Contract Coordinator section with contact and mailing address details for Sam Grader.

Additional Staff section with contact and mailing address details for Kathy Nagel.

Additional Staff section with blank contact and mailing address fields.