Texas Department of Health

ASSOCIATESHIP FOR COMMUNITY HEALTH AND RESOURCES DEVELOPMENT

TITLE V - FEE FOR SERVICE

REQUEST FOR PROPOSAL

FISCAL YEAR 2001

APPLICATION DUE

April 19, 2000

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A. INTRODUCTION

The Texas Department of Health (TDH) announces the availability of Fiscal Year 2001 (FY 01) funds under the Maternal and Child Health Services Block Grant, Title V of the Social Security Act. This RFP is the fifth continuation year for the previously competitively awarded Fiscal Year 1997 (FY 97) funding for Title V. Your agency may not apply for additional Title V fee-for- service funding beyond what you were awarded in Fiscal Year 2000 (FY 00). As this is a continuation application, all selected contractors are expected to continue to provide services/units of service in or benefitting the county(ies)/area as defined in the prior budget period contract, unless specifically stated in your application (e.g., as a result of a clinic closure or a previously approved program revision). All agencies must complete: 1) the continuation RFP and 2) the Assurances and Certifications.

B. FUNDING PERIOD

All applicants will be applying for the 12-month budget period of September 1, 2000, through August 31, 2001. This RFP will be applicable only for FY 2001. The contract period will begin on or about September 1, 2000.

C. PROGRAM INFORMATION

The general purpose of the Texas Title V Maternal and Child Health Services Block Grant is to improve the health of all mothers and children by funding direct clinical services (fee-for-services program) and population-based public health activities. Whenever possible, it is anticipated that these services will be incorporated into a comprehensive medical home. More specific purposes of the two TDH Title V Programs are to reduce low birth weights and infant mortality; reduce and potentially eliminate the incidence of preventable diseases and handicapping conditions; reduce the need for inpatient and long-term care services; increase the number of children who are properly immunized; and reduce the incidence of unintended pregnancies.

ALLOWABLE USE OF PROGRAM FUNDS

Title V Fee-for-Service funds are to be used for clinical services that are provided to persons on an individual basis and include: prenatal care, preventive and primary child health care, family planning, case management for high-risk pregnant women and infants, dysplasia, and dental care for children and adolescents. Only allowable services are reimbursed through established rates. Only non-Medicaid clients below 185% of the federal poverty income limits (FPIL) are eligible for services.

D. PROGRAM REQUIREMENTS

In addition to individual program-related standards for Title V Fee-for-Services, all contractors are required to conduct project activities in accordance with Quality Care: Client Services Standards for Public Health and Community Clinics (revised June, 1997). To obtain a copy, contact TDH Community Health Nursing

at 512-458-7773. Contractors are required to provide services in accordance with the policies and procedures detailed in the FY 2000 Title V Policies and Procedures Manual for Maternal and Child Health Services.

FISCAL REQUIREMENTS

Title V Fee-for-Services Eligibility is based on family size and income. Title V clients must be screened for potential Medicaid eligibility and must fall at or below 185% of the fpl. No clients below 100% of the FPIL can be charged for services. A co-payment may be charged to clients from 100-185% of FPIL based on a sliding scale fee which must be approved by TDH. The eligibility process must be based on self declaration of their income and no proof will be required.

PROGRAM INCOME POLICIES

Program income is defined as gross income derived by an agency provider from fees or charges collected that are made in connection with the delivery of program services (family planning and/or maternal and child health) supported in whole, or in part, by a publicly funded grant/contract. All program income must be used by the provider during the contract year to further the operation of the program for which the contract was made.

Revenue collected as co-payment (program income) from Title V fee-for-services clients must be returned to the program and must be reported as program income in compliance with TDH standards. A TDH Form 270 which identifies program income must be submitted at the end of the contract period.

E. RFP TIME LINES

RFP kit available to applicants	March 15, 2000
Application Submission Deadline to TDH	5:00 p.m. C.D.T., April, 19, 2000
Written Notification to All Applicants of Funding Decisions	May, 30, 2000
Contract Development and Execution	June 19, 2000 - August 31, 2000
Contract Effective Date	September 1, 2000

F. GETTING YOUR RFP QUESTIONS ANSWERED

For questions about this RFP, the contact person is listed below. Employees and representatives of TDH other than those listed below may not answer questions or otherwise discuss the content of the RFP with applicants. Failure of an applicant to observe this restriction may result in disqualification of any subsequent application. By using the appropriate contact person, you receive accurate and consistent information.

If you would like to have a written response to a question about the RFP, your written inquiry must be received no later than 5:00 p.m. Central Daylight Savings Time (C.D.T.) on April 14, 2000. General responses will be distributed to all providers who received a copy of this RFP. Responses to a specific

inquiry will be provided only to the requestor. TDH is the only entity who can decide whether a request is of a general or specific nature.

The Associateship's Contract Management Section is the sole point of contact with regard to all procurement and contractual matters relating to the Title V services/activities described in the RFP. The Associateship's Contract Management Section is the only office authorized to clarify, modify, amend, alter, or withdraw the project requirements, terms, and conditions of the Title V fee-for-service RFP and any contract awarded as a result of this RFP.

Paula Daniels
Contract Management Section - M370
Bureau of Nutrition Services
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

Phone: 512-458-7111 ext. 2950
Fax: 512-458-7203
E-mail: paula.daniels@tdh.state.tx.us

The above address should be used for overnight and personal deliveries.
*****If you hand-deliver your application, be sure to request a receipt at the time of delivery.

G. APPLICATION DUE DATE, ASSEMBLY, AND FORMATTING

DUE DATE

Your application must be *received* by 5:00 C.D.T. on April 19, 2000. *Applications received after the deadline will not be considered for review*. Please refer to the section below to determine the number of originals and copies you will need to submit.

ASSEMBLY

An original and two copies of the completed proposal must be submitted to the Title V Program staff named below**;** an additional two copies of the proposal must be sent to the appropriate Public Health Regional Director. Your proposal should be addressed to:

Paula Daniels
Contract Management Section - M370
Bureau of Nutrition Services
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

Public Health Regional Director
(See RFP Appendix Section A)

FORMATTING

- ❒ Applicants who propose to serve counties in more than one region must submit two copies to each Regional Director for every region proposed to be served.
- ❑ Faxes and incomplete applications will NOT be accepted.
- ❑ Responses must be submitted in hard copy format only (no electronic formats).
- ❑ Each application should have a Table of Contents which follows the RFP Table of Contents.
- ❑ All pages should be clearly and sequentially numbered.
- ❑ The original(s) and each copy must be submitted unbound.
- ❑ All materials must be: 1) typed (computer or typewriter), 2) single-spaced, 3) 12-point font on 8½" x 11" paper with 1" margins, and 4) printed on one side only.
- ❑ Completed applications must be signed in ink by an authorized official and submitted with the required number of copies.

H. APPLICATION REVIEW, EVALUATION, AND NEGOTIATION

APPLICATION REVIEW

Proposals will be reviewed by teams in the central office of TDH and the public health regions in the appropriate geographic region of the proposed project, using the evaluation criteria outlined below. Each team's recommendations will be discussed and staff will jointly make the final determination of funding. To ensure fairness for all applicants during the review period, TDH staff may only confirm receipt of an application and cannot discuss the application itself during the review process. All applications will remain with TDH and will not be returned to the applicant.

It is TDH's intent to award contracts based upon the response to this RFP. Applicants will be prioritized according to the applicants' ability to establish services or provide services for the areas of the state outlined in this RFP.

Applications are initially screened for eligibility and completeness. Applicants who do not meet the requirements in the RFP may not be considered for review, and the applicant will be notified in writing. A standardized review process will be used, and review tools will be developed based on the following criteria.

TITLE V FEE-FOR-SERVICE EVALUATION

Review Criteria

All required forms from the consolidated section are signed by an authorized person.
The RFP Continuation Assessments have been completed and "yes" answers are explained.
The ceiling requests for activity codes 185 and 186 are completed.
At least 25% of the total dollars requested are dedicated to children and adolescents (185).
The total amount requested does not exceed your current (FY 00) year's ceiling.
Title V assurances have been signed and dated by an authorized person.

NEGOTIATION

Once an award is made, a contract negotiation process is initiated. Applicants selected for contract awards may be asked to revise the budget they submitted, as well as their goals and objectives,

based on the available funding. Selected applicants will submit their changes in writing. Once the contract negotiation process is complete, TDH initiates the development of a contract.

Each applicant whose application is selected for a contract will receive written notification. The notice, however, is not legally binding until there is a fully executed contract. If you are not selected for contract renewal, you will also be notified in writing.

I. TDH ADMINISTRATIVE INFORMATION

Incurring Costs and Rejection of Applications

Any costs incurred in the preparation of the application shall be borne by the applicant and are not allowable costs. TDH reserves the right to reject any or all applications and is not liable for any costs incurred by the applicant in the development, submission, or review of the application.

Right to Amend or Withdraw RFP

TDH reserves the right to alter, amend, or modify any provisions of this RFP or to withdraw this RFP at any time prior to the execution of a contract pursuant thereto if it is in the best interest of TDH and the State of Texas. The decision of TDH will be administratively final in this regard.

Financial and Administrative Requirements

All current contractors administering two or more TDH contract attachments are required to maintain integrity between the transactions affecting each contract attachment by: 1) maintaining a

completely separate set of records for each contract attachment; or 2) establishing within the chart of accounts and general ledger a separate set of accounts for each contract attachment. (Title V Fee-for Services contractors and Population-Based Public Health Projects are separate contracts.)

The applicant is encouraged to secure additional funds from other sources as necessary to strengthen the overall application.

SECTION 1

TITLE V - FEE FOR SERVICE
APPLICATION CHECKLIST

Legal Name of Applicant _____

INSTRUCTIONS: This Checklist must be completed and submitted with the original application. It is provided to ensure that the application is complete, proper signatures are included, and the required assurances, certifications and attachments have been submitted. Application is typed (computer or typewriter), single-spaced on 8 ½" x 11" white paper and does not exceed page limits where specified. Confidential information is clearly marked in the application and reasons the information should be confidential are stated.

APPLICATION CONTENT		Included	N/A
A.	Application Checklist is completed and attached to original application	_____	_____
B.	Face Page - Application for Financial Management	_____	_____
C.	Medicaid Program Status Table	_____	_____
D.	Clinic Forms	_____	_____
E.	Quality Assurance Information	_____	_____
F.	Staff organization Chart	_____	_____
G.	Title V - Fee for Service Cover Sheet	_____	_____
H.	Continuation Assessment	_____	_____
I.	Progress Report	_____	_____
J.	Service Delivery Plan	_____	_____
K.	Completed Activity Code 186	_____	_____
L.	Completed Activity Code 185	_____	_____
M.	HUB Good Faith Effort	_____	_____
N.	(HUB) Progress Assessment Report	_____	_____
O.	Laboratory and Pharmacy Registration	_____	_____
P.	Title V Project Assurances	_____	_____

TEXAS DEPARTMENT OF HEALTH

Face Page - Application for Financial Assistance

1. APPLICANT INFORMATION

1A. Legal Name:

1B. Address (include Street & Mailing Addresses, City, County, State and Zip Code):

1C. PAYEE Name and Mailing Address (if different from Applicant):

1D. Federal Tax Identification No. or State of Texas Comptroller Vendor Identification No. (14 digit):

1E. Applicant's Legal Authority to Contract:

2. TYPE OF ENTITY (enter appropriate letter in box): ☐ If response is F. or G., is entity a HUB? Yes/No _____

A.	City	E.	Nonprofit Organization*	I.	Other (specify) _____
B.	County	F.	Individual		
C.	Other Political Subdivision	G.	For Profit Organization*		
D.	State Agency	H.	State Controlled Institution of Higher Learning		

* If incorporated, provide 10-digit charter number assigned by the Secretary of State _____

3. PROPOSED BUDGET PERIOD: Start Date _____ End Date_____

4. COUNTIES AFFECTED BY PROJECT:

5. AMOUNT OF FUNDING REQUEST:

6. The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in this RFP. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award or continuation of a contract. 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.

6A. Typed Name & Title of Authorized Representative	6B. Telephone Number ( )
6C. Signature of Authorized Representative	6D. Date

MEDICAID STATUS TABLE

PROGRAM	Medicaid Number(s) (Date began billing for services)
Prenatal Care	
EPSDT Medical (Texas Health Steps)	
Primary Child Health Care	
Family Planning	
Case Management for High Risk Pregnant Women and Infants (PWI)	
Dysplasia	
EPSDT Dental (Texas Health Steps)	

CLINIC FORMS

A separate clinic form **must** be filled out for each clinic site.
Indicate which of the following funding sources support services at this clinic:
V ❑ X ❑ XIX ❑ XX ❑

Agency and Clinic Name: _____
Location of Site: Street Address: _____
City: _____ County: _____
PHR: _____
Contact Person: _____ Telephone Number: (_____) _____

DAY	SPECIFIC TYPE OF SERVICES PROVIDED/CLINIC TYPE	DAILY HOURS OF OPERATION	MONTHLY NUMBER OF CLINICS	APPROXIMATE NUMBER OF PATIENTS SEEN DAILY
Monday Morning				
Afternoon				
Evening				
Tuesday Morning				
Afternoon				
Evening				
Wednesday Morning				
Afternoon				
Evening				
Thursday Morning				
Afternoon				
Evening				
Friday Morning				
Afternoon				
Evening				
Saturday Morning				
Afternoon				
Evening				

QUALITY ASSURANCE

Provide a narrative describing your internal quality assurance (QA) activities which identifies the role of your QA committee, the composition and credentials of your QA committee, what outcomes have/will be identified, and what system has been developed for tracking outcomes. (Do not exceed 1½ pages.)

QUALITY ASSURANCE (continued)

STAFF ORGANIZATION CHART

Attach an organizational chart showing all staff involved in the service delivery . Indicate whether each position is New (N), Existing (E), or Vacant (V).

SECTION II
TITLE V - FEE FOR SERVICE

INTRODUCTION

This Request for Proposal (RFP) is the fifth year continuation of the competitive RFP which began in fiscal year (FY) 1997.

The FY 97 competitive RFP was awarded based on groupings of counties. Counties with smaller populations were combined with counties with larger populations in order to assure services in less populated areas.

Contractors must complete this application for the same service area as their FY 97 competitive application (unless additional counties and funding were added to your service area through subsequent RFP's issued for selected areas.)

However, contractors may choose to contract with subrecipients in specific areas as long as the contractor assures the availability of service and the quality of the service provided. Any sub-contractual arrangement must be detailed in this RFP and follow the criteria as outlined in the FY 00 Title V Policies and Procedures Manual for Maternal and Child Health Services, Section I, Page 16.

Your FY 01 ceiling request for activity codes 185 and 186 should be no greater than your FY 00 (current year) ceiling (even if you reach your ceiling prior to the end of the fiscal year).

Billing changes for Title V Family Planning, effective 9/1/2000:

Beginning in FY 01, the Title V Family Planning claims processing and reimbursement process will change significantly. These changes will affect ***only*** the family planning portion of Title V. These changes go into effect 9/1/2000.

The Title V monthly aggregate billing forms will no longer be accepted for Title V family planning claims. Beginning September 1, 2000, Compass 21, the new claims processing system at National Heritage Insurance Company (NHIC), must be used to submit Title V family planning claims for reimbursement. Family Planning claims must be billed on the new Family Planning 2017 Claim Form. Claims can be submitted electronically or on paper, and they can be submitted individually or in batches on a schedule determined by the contractor.

Family Planning visits will no longer be reimbursed using the fixed rates. Contractors will need to bill for each service provided during a visit. The billable procedure codes will expand to mirror those services billable under Title XX. The reimbursement rates for these procedures will be based on the Title XIX Medicaid rates.

If the Compass 21 System is delayed and is not running by September 1, 2000, you will be notified to continue using the Title V monthly aggregate billing forms (i.e., Forms 185 and 186).

Once Compass 21 takes effect, Family Planning Form 2017 claim form will be available to you and consequently, Forms 185 and 186 will be revised by removing the family planning services section.

The laboratory policy regarding pharmacy supplies and services will not change. Family planning contractors will continue to be able to submit specimens for Title V clients to TDH labs, which have been pre-paid by Title V to provide selected lab tests at no additional cost to contractors. Please note that Title V does not reimburse for lab specimens submitted to other than TDH laboratories.
NHIC will send payment information to TDH on a weekly basis, so contractors can be reimbursed weekly. A weekly Remittance and Status (R&S) report will be sent by NHIC to contractors providing information on claim status.

A family planning budget ceiling amount will be agreed upon by the contractor and the Title V representative based on an assessment of the contractor's family planning requirements. This will be the amount against which the contractors' family planning claims will be billed. If this ceiling amount needs to be raised or lowered during the fiscal year, contractors will negotiate the required change with the Title V representative.

TITLE V - FEE FOR SERVICE COVER SHEET

1.	**MCH Director:**
1a.	Phone Number: ( )
1b.	Fax Number: ( )
1c.	Email Address:
2.	**Quality Assurance Coordinator:**
2a.	Phone Number: ( )
2b.	Fax Number: ( )
2c.	Email Address:
3	**Person Completing Title V Fee-for-Service Application:**
3a.	Title:
3b.	Phone Number: ( )
3c.	Email Address:
4.	**Do you have on-site pharmacies in your clinics?** ❑ **Yes** ❑ **No** **If yes, check one:** ❑ **Class A** ❑ **Class D** ❑ **Both**
5.	**Counties to be served:**

CONTINUATION ASSESSMENT

1. **Is your service plan changing from your originally submitted FY '97 Competitive RFP?**
   ❑ Yes ❑ No
   If yes, please explain _____

2. **Will your service area change?**
   ❑ Yes ❑ No
   If yes, please explain _____

3. **Will you be changing from direct service delivery to contracts with subrecipients for service delivery?**
   ❑ Yes ❑ No
   If yes, please explain _____

4. **Will your unduplicated numbers of clients change 15% or more?**
   ❑ Yes ❑ No
   If yes, please explain _____

5. **Have you had a significant change in staff in the current year?**
   ❑ Yes ❑ No
   If yes, please explain _____

6. **Have there been any major changes in your community (e.g. loss of other resources)?**
   ❑ Yes ❑ No
   If yes, please explain _____

7. **Have you lost funds through the discontinuation of other grants or the loss of local funds?**
   ❑ Yes ❑ No
   If yes, please explain _____

8. **Have you opened or closed clinics in the current year?**
   ❑ Yes ❑ No
   If yes, please explain _____

9. **Do you offer extended clinic hours prior to 8:00 am, evening hours after 5pm, and/or on weekends?**
   ❑ Yes ❑ No
   If yes, please explain _____

10. **Are you having difficulty obtaining Medicaid denial letters from DHS clients?**
    ❑ Yes ❑ No
    If yes, please explain _____

PROGRESS REPORT

Provide a progress report on the provision of services since you submitted your FY 00 continuation application (not to exceed two pages). Include any expansion, any services you are particularly proud of, pilot projects, and any problems that you have encountered with delivery of services.

PROGRESS REPORT (continued)

SERVICE DELIVERY PLAN

If applicable, **describe any anticipated changes in your plan for FY 2001** for the Title V Maternal and Child Health service delivery in your proposed service area(s). Do not exceed 3 typewritten pages, including this page.

SERVICE DELIVERY PLAN (Page 2)

SERVICE DELIVERY PLAN (Page 3)

TITLE V CEILING REQUEST

Instructions for Completing the FY 2001 Ceiling Requests (185 & 186).

Activity Code 185 - Complete for Children ages 1 through 21st year.
Activity Code 186 - Complete for infants birth to one year and women 22 and over.

Complete the first box of the two forms labeled "PHR " and "County." If you are serving multiple counties, complete forms 185 and 186 for each county.

Fill in the column marked "client #" with the unduplicated number of clients anticipated to be seen for each service you provide and propose to bill for reimbursement. This column should reflect accurately all services listed in your Service Plan for which you intend to bill and expect to be paid. Billings for services not listed will not be paid prior to submission of an approved revised service plan.

The column marked quantity will be completed with the number of services to be billed (in many instances this will be a total visit count).

(For example:)
Prenatal initial visit unduplicated client # of 25, quantity = 25 X 1= 25, 25 X $115 rate= $2875 .
Return or Postpartum Visit. Unduplicated client # of 25. Quantity 25 X 8 visits = 200. 200 X $48 rate=$9,600.

Client #	Service	Rate	Quantity	Amount
25	Initial Visit	115	25	2875
25	Return or Postpartum visit	48	200	9600

Total the amount column on the 185 and on the 186 ceiling requests.
Total the two amounts together at the bottom of the 185.

Combine all the county breakdowns, and mark them as totals for the region. If you are serving more than one region, you must have totals for 185 and 186 for each region.

Activity Code 186	PHR:	County:		
		WOMEN AND INFANTS SERVICES		
CLIENTT	SERVICE	RATE	QUANTITY	AMOUNT
		PRENATAL		
	Initial Visit	115.00		
	Return or Postpartum Visit	48.00		
	Complete Ultrasound	100.00		
	Follow-up Ultrasound	55.00		
	Comprehensive Ultrasound	175.00		
	Follow-up Comprehensive Ultrasound	95.00		
	Non Stress Test	35.00		
	Nutritionist Visit	30.00		
	High Risk Case Management - Face to Face	35.00		
	High Risk Case Management - Telephone	12.00		
		CHILD HEALTH (0-1)		
	Well Child Visit	58.00		
	Sick Child Visit	44.00		
	Follow-up Child Visit	18.00		
	Nutritionist Visit	30.00		
	High Risk Case Management - Face to Face	35.00		
	High Risk Case Management - Telephone	12.00		
		FAMILY PLANNING		
	Initial Visit	70.00		
	Capitated Annual Rate	162.00		
	Pregnancy Test Visit	20.00		
	Depo-Provera	21.00		
	Furnish & Insert IUD	282.00		
	IUD Removal	35.00		
	Furnish & Insert Norplant	490.00		
	Norplant Removal	150.00		
	Tubal Ligation	1,200.00		
	Vasectomy	250.00		
	Nutritionist Visit	30.00		
	Annual Gynecology Exam	70.00		
		DYSPLASIA		
	Initial Visit	60.00		
	Return Visit	34.00		
	Colposcopy	50.00		
	Colposcopy & Biopsy	80.00		
	Conservative Treatment Return Visit (e.g. cyro, LEEP, laser)	125.00		
			Total AC 186	

Contractor Name: _____

Activity Code 185 **PHR:** **County:**

CLIENT	SERVICE	RATE	QUANTITY	AMOUNT
	PRENATAL			
	Initial Visit	115.00		
	Return or Postpartum Visit	48.00		
	Complete Ultrasound	100.00		
	Follow-up Ultrasound	55.00		
	Comprehensive Ultrasound	175.00		
	Follow- up Comprehensive Ultrasound	95.00		
	Non Stress Test	35.00		
	Nutritionist Visit	30.00		
	High Risk Case Management - Face to Face	35.00		
	High Risk Case Management - Telephone	12.00		
	CHILD HEALTH			
	Well Child Visit	58.00		
	Sick Child Visit	44.00		
	Follow-up Child Visit	18.00		
	Nutritionist Visit	30.00		
	Combined WC/FP Visit	30.00		
	FAMILY PLANNING			
	Initial Visit	70.00		
	Capitated Annual Rate	162.00		
	Pregnancy Test Visit	20.00		
	Depo-Provera	21.00		
	Furnish and Insert IUD	282.00		
	IUD Removal	35.00		
	Furnish and Insert Norplant	490.00		
	Norplant Removal	150.00		
	Nutritionist Visit	30.00		
	DYSPLASIA			
	Initial Visit	60.00		
	Return Visit	34.00		
	Colposcopy	50.00		
	Colposcopy and Biopsy	80.00		
	Consertative Treatment (e.g. cyro, Leep, laser)	125.00		
	DENTAL			
	Preventative Visit	80.00		
	Treatment Visit	80.00		

TOTAL A.C. 185	
TOTAL A.C. 186	
GRAND TOTAL	

Contractor Name: _____

SECTION III
FORMS AND ASSURANCES

TEXAS DEPARTMENT OF HEALTH

HUB GOOD FAITH EFFORT PROGRAM(GFEP)/CLIENT SERVICES FORM

In accordance with Texas Government Code Title 10, Subtitle D, Chapter 2161 and Title 1 Texas Administrative Code (TAC) §111.11 through §111.24, state agencies are required to make a good faith effort to assist historically underutilized businesses (HUBs) in receiving contract awards issued by the state. The goal of this program is to promote full and equal business opportunities for all businesses in contracting with the state. See back of form for HUB definition.

The Texas Department of Health (TDH) is very committed to the HUB program and shall make a good faith effort to utilize HUBs in contracts for commodities and service purchases. TDH will achieve annual program goals by contracting directly with HUBs or indirectly through subcontracting opportunities. A *subcontractor* is an entity that enters into a contract with a contractor (vendor) to provide the goods or services for which the contractor is responsible under the terms of its contract with TDH.

It is the intent of TDH that *all* TDH contractors make a good faith effort to subcontract with HUBs during the performance of their contract; however, **any business that enters into a Client Services contract with TDH for $100,000 or more shall be required to make a good faith effort to award subcontracts to HUBs to meet the goal of 18.10%.** Any combination of the following subcontracting areas may be used to satisfy this goal:

Commodity purchases (e.g. medical supplies, office supplies, laboratory supplies)
Professional Services (e.g. physicians, nursing, laboratory services, pharmacy)
Other Services (e.g. legal services, consulting, maintenance/repair services, computer services)

This Good Faith Effort Program goal does not prevent any business group from participating in contracting opportunities with the State of Texas. Further assistance and/or copies of the applicable sections of 1 TAC can be obtained by contacting the TDH HUB Program at (512) 458-7111, extension 3760 or 1-800-243-7487.

INSTRUCTIONS:

Applications for contract funds totaling less than $100,000 - Applicants are encouraged to voluntarily comply with the HUB Good Faith Effort Program, complete and return this HUB Good Faith Effort Program/Client Services Form with the application, and if a contract is awarded, to submit Quarterly Reports regarding HUB subcontracting activity. However, for applications less than $100,000, completion of this form and Quarterly Reports are not mandatory.

Applications for contract funds totaling $100,000 or more - Applicants are required to: comply with the HUB Good Faith Effort requirements, complete and return this HUB Good Faith Effort Program/Client Services form along with a supplemental letter as explained below (#3) with the application or no later than 7 working days following the submission of the original application, and if a contract is awarded, to submit appropriate Quarterly Reports regarding HUB subcontracting activity. For applications totaling $100,000 or more, compliance with these requirements is a condition of awarding a contract.

1. Are you certified as a Texas Historically Underutilized Business (HUB)? _____Yes _____No
If "Yes" - What percentage of the contract work will be completed by your employees? _____

2. If an award is issued, do you plan to utilize a HUB Subcontractor or Supplier for all or any portion of the contract?
_____Yes_____No If "Yes" - What percentage of the total dollar amount of the award will be or is estimated to be subcontracted? _____

3. Attach supplemental documentation based on your answer to question #2 as follows: If "Yes"- List specific subcontracting or supply areas that compose the percentage amount listed; if "No"- Provide written explanation.

Quarterly Reports (Due December, March, June and September)**:** If TDH determines you have complied with the good faith effort requirements and awards you a contract, you will be required to submit one of the following quarterly reports if you provide any HUB subcontracting opportunities:

Non-HUB Vendors: *Progress Assessment Report by Non-Historically Underutilized Businesses of Work Sub-Contracted* (NON-HUB-PAR).
HUB Vendors: *Progress Assessment Report by Historically Underutilized Business of Work Sub-Contracted* (HUB-PAR-A).

Applicant Representative Signature:_____

NOTE: A list of all General Service Commission certified HUBs may be electronically accessed through the Internet. Using a Web Browser (like Netscape, Mosaic, etc.), connect to **http://www.gsc.state.tx.us** (this is the GSC home page).

HUB DEFINITION

A HUB is defined in the Texas Government Code §2161.001(2), VTCA, as an entity with its principal place of business in this state that is:

A. a corporation formed for the purpose of making a profit in which 51 percent or more of all classes of the shares of stock or other equitable securities are owned by one or more economically disadvantaged persons who have a proportionate interest and actively participate in the corporation's control, operation, and management;

B. a sole proprietorship created for the purpose of making a profit that is completely owned, operated, and controlled by a economically disadvantaged person;

C. a partnership formed for the purpose of making a profit in which 51 percent or more of the assets and interest in the partnership are owned by one or more economically disadvantaged persons who have a proportionate interest and actively participate in the partnership's control, operation, and management;

D. a joint venture in which each entity in the venture is a historically underutilized business, as determined under another paragraph of this subdivision; or

E. a supplier contract between a historically underutilized business as determined under another paragraph of this subdivision and a prime contractor under which the historically underutilized business is directly involved in the manufacture or distribution of the goods or otherwise warehouses and ships the goods.

"Economically disadvantaged person" is defined in Texas Government Code §2161.001(3) as ". ....a person who is economically disadvantaged because of the person's identification as a member of a certain group, including Black Americans, Hispanic Americans, women, Asian Pacific Americans and Native Americans, and who has suffered the effects of discriminatory practices or other similar insidious circumstances over which the person has no control."

TDH
TEXAS DEPARTMENT OF HEALTH

PROGRESS ASSESSMENT REPORT BY NON-HISTORICALLY UNDERUTILIZED BUSINESS OF WORK SUB-CONTRACTED (NON-HUB-PAR)

Contractor Name:_____
Vendor Identification Number(VID#):_____
Mailing Address:_____
Total Contract Amount: $_____
Total Amount Paid to HUB Subcontractor(s): $_____

For HUB Subcontractor/Supplier, write in the letter "H" and the GSC Certification #. If NON-Certified HUB Subcontractor, write in the letter "N."	Name of Subcontractor/ Supplier	VID#, Social Security or Federal ID Number	$Amount Paid This Period	$ Total Paid to Date

To be reported quarterly by the following dates:

Quarter	Months Included	Deadline
First	Sept., Oct., Nov.	December 5th
Second	Dec., Jan., Feb.	March 5th
Third	March, April, May	June 5th
Fourth	June, July, Aug.	September 5th

Signature _____
Title _____
Date _____
Telephone # _____

Return to: Texas Department of Health
Attn: TDH HUB Coordinator
Bureau of Support Services
1100 West 49th Street
Austin, Texas 78756

Attach a narrative report describing your good faith efforts during the reporting period.

TDH
TEXAS DEPARTMENT OF HEALTH

PROGRESS ASSESSMENT REPORT BY HISTORICALLY UNDERUTILIZED BUSINESS OF WORK SUB-CONTRACTED (HUB-PAR)

Contractor Name: _____
Vendor Identification Number (VID#) _____
Mailing Address: _____
Total Contract Amount: $_____**Total Amount Paid to HUB Subcontractor(s): $**_____
% of Contract performed by Contractor's employees for reporting period:_____

For HUB Subcontractor/Supplier, write in the letter "H" and the GSC Certification #. If NON-Certified HUB Subcontractor, write in the letter "N."	Name of Subcontractor/ Supplier	VID#, Social Security or Federal ID Number	$Amount Paid This Period	$ Total Paid to Date

To be reported quarterly by the following dates:

Quarter	Months Included	Deadline
First	Sept., Oct., Nov.	December 5th
Second	Dec., Jan., Feb.	March 5th
Third	March, April, May	June 5th
Fourth	June, July, Aug.	September 5th

Signature _____
Title _____
Date _____
Telephone #_____

Return to: Texas Department of Health
Attn: TDH HUB Coordinator
Bureau of Support Services
1100 West 49th Street, G-103
Austin, TX 78756

Attach a narrative report describing your good faith efforts during the reporting period.

DISCLOSURE OF LOBBYING ACTIVITIES
Complete this form to disclose lobbying activities pursuant to 31 USC 1352
(See reverse for public burden disclosure.) Approved by OMB 0348-0046

1. Type of Federal Action: ❑ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	2. Status of Federal Action ❑ a. bid/offer/application b. initial award c. post-award	3. Report Type: ❑ a. initial filing b. material change For Material Change Only: Year _____ Quarter _____ Date of last report _____
4. Name and Address of Reporting Entity: ❑ Prime ❑ Subawardee Tier _____ # known: Congressional District, if known:		5. If Reporting Entity in No. E is Subawardee, Enter Name Of Prime: Congressional District, if known:
6. Federal Department/Agency		7. Federal Program Name/Description: CFDA Number, if applicable_____
8. Federal Action Number, if known:		9. Award Amount, if known: $
10a Name and Address of Lobbying Entity (If individual, last name, first name, MI): (Attach Continuation)	b. Individuals Performing Services (including address is different from No. 10a) (last name, first name, MI): (Sheets(s) SF-LLL-A, if necessary)	
11. Amount of Payment (check all that apply): $ _____ ❑ actual ❑ planned	13. Type of Payment (check all that apply): ❑a. retainer ❑b. one-time fee ❑c. commission ❑d. contingent fee ❑e. deferred ❑f. other, specify: _____	
14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for Payment indicated in item 11. (Attach Continuation Sheet(s) SF-LLL_A, if necessary)		
15. Continuation Sheet(s) SF-LLL-A attached: ❑ Yes ❑ No		
16. Information requested through this form is authorized by Title 31 USC Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 USC 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $10,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Legal Name of Applicant: _____ Telephone Number: _____ Date: _____	
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL	

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Approved by OMB
0348-0046

Reporting Entity: _____ Page _____ of _____

Authorized for Local Reproduction
Standard Form - LLL-A

INSTRUCTIONS FOR COMPLETION OF SF-LLL
DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipient, at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31 USC §1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include congressional district, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g. the first subawardee of the prime is the first tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in Item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime federal recipient. Include congressional district, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract, grant, or loan award number, the application/proposal control number assigned by the federal agency). Include prefixes, e.g., “RFP-DE-90-001.”

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter last name, first name, and middle initial (MI)

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If “other,” specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget. Paperwork Reduction Project (0348-0046), Washington, D.C. 20503.

TITLE V CONTRACTOR
LABORATORY AND PHARMACY REGISTRATION

****COMPLETE FOR **EVERY** SITE THAT WILL RECEIVE SUPPLIES AND/OR LAB RESULTS****

Name of Agency:
Clinic Name with Physical Address (including site name and city):
Mailing Address: (include city and ZIP)
Phone: FAX: E-mail:
Contact Person/Phone Number for Lab Issues: E-mail address:
Contact Person/Phone Number for Pharmacy Issues: E-mail address:

SERVICES PROVIDED BY THE AGENCY:

___ Maternity ___ Family Planning ___ Child Health ___ Texas Health Steps

Estimated Number of Clients Anticipated by Service per Year:

_____ Maternity _____ Family Planning

_____ Child Health _____ Texas Health Steps (EPSDT)

. . . **** THS (EPSDT) Provider #**_____

Pharmacy Classification:_____

TITLE V PROJECT ASSURANCES

I agree to conduct my Project in compliance with the requirements and intent of the Title V Maternal and Child Health Block Grant and the Texas Department of Health (TDH), Associateship for Community Health and Resources Development follows:

A. To conduct Fee-For-Service and/or Population-Based Public Health Project activity(ies) in a culturally sensitive and nondiscriminating manner.

B. To conduct Fee-For-Service and/or Population-Based Public Health Project activity(ies) as outlined in this application's plan and to notify the appropriate Title V Coordinator listed below prior to any significant departures from this plan.

Fee-For-Service - Paula Daniels, 512-458-7111 ext. 3410, paula.daniels@tdh.state.tx.us
Population-Based -Zanette Hammonds, 512-458-7111 ext. 6445, zanette.hammonds@tdh.state.tx.us

C. To return 100% of any Title V generated program income to the MCH program which generated the funds.

D. To screen clients for potential Medicaid eligibility, refer to TDHS those who screen out as potentially eligible and maintain Medicaid denial letters, on those who are denied.

E. To provide TDH with reasonable access to all data gathered or generated through this project.

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

G. To grant TDH rights to all tangibles, patentable, or copyrightable products developed with Federal and State funds.

H. To spend at least 25% of total allocated Title V funds for the provision of activities to children and adolescents ages one (1) through twenty-one (21).

I. To make available for TDH review, all promotional materials/media to be disseminated in conjunction with this Fee-For-Service and/or Population-Based Public Health Project.

J. To comply with all applicable Title V policies, procedures, and regulations.

_____ _____
Authorized Signature Date

APPENDIX A
REGIONAL DIRECTORS

PUBLIC HEALTH REGIONS

REGION	REGIONAL DIRECTOR	ADDRESS	PHONE NUMBER	FAX NUMBER
1	**John Huss, Acting Director** John.Huss@tdh.state.tx.us	**1100 Kemper Lubbock 79403**	**806-744-3571**	**806-741-1366**
2/3	**James A Zoretic, MD, MPH** James.Zoretic@tdh.state.tx.us	**1351 East Bardin Arlington, 76018**	**817-264-4455**	**817-264-4420**
4/5N	**Paul K. McGaha, DO, MPH** Paul.McGaha@tdh.state.tx.us	**1517 West Front Street Tyler, 75702**	**903-595-3585**	**903-595-4187**
6/5S	**H. Mark Guidry, MD, MPH** Mark.Guidry@tdh.state.tx.us	**5425 Polk, Suite J Houston, 77023**	**713-767-3000**	**713-767-3049**
7	**James K. Morgan, MD, MPH** James.Morgan@tdh.state.tx.us	**2408 South 37th Street Temple, 76054-7168**	**254-778-6744**	**254-778-4066**
8	**W.S. Riggins, Jr., MD, MPH** Chip.Riggins@tdh.state.tx.us	**7430 Louis Pasteur Drive San Antonio, 78229**	**210-949-2000**	**210-949-2015**
9/10	**Miguel A. Escobedo, MD, MPH** Miguel.Escobedo@tdh.state.tx.us	**6070 Gateway East, Suite 401 El Paso, 79995-9428**	**915-774-6201**	**915-783-1138**
11	**Brian Smith, MD, MPH** Brian.Smith@tdh.state.tx.us	**601 West Sesame Drive Harlingen, 78550**	**956-423-0131**	**956-444-3298**

APPENDIX B
GENERAL PROVISIONS

APPENDIX C
FAMILY PLANNING STANDARDS