The Houston Regional HIV/AIDS Resource Group, Inc.

2025-2028 Request for Proposals

Housing Opportunities for Persons with AIDS (HOPWA)

Application Forms and Narrative

Proposals Due: July 17, 2025, 5:00p (CT)

Refer to RFP Guidance for more details

The Houston Regional HIV/AIDS Resource Group, Inc.

**FORM A: FACE PAGE**

|  |
| --- |
| This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the application and shall be completed in its entirety. Signature on face page certifies to all HUD, DSHS, and program assurances listed in this application document.   |
| 1. | Legal Business Name |       |
| 2. | Physical Address |       |
| 3. | Mailing Address |       |
| 4. | Payee Name |       |
| 5. | Payee Mailing Address |       |
| 6. | Unique Entity ID Number |       |
| 7. | Federal Tax ID,Texas Comptroller Vendor ID, orSocial Security Number\* |      *\*The applicant acknowledges, understands, and agrees that using a Social Security number as its contractual vendor identification number may result in the number becoming public via state open records requests.* |
| 8. | Type of Entity | Check all that apply |
|  | [ ]  City | [ ]  Nonprofit Organization\*  | [ ]  Individual |
|  | [ ]  County | [ ]  For Profit Organization\*  | [ ]  Federally Qualified Health Center |
|  | [ ]  Other Political Subdivision | [ ]  Historically Underutilized Business | [ ]  State Controlled Institution of Higher Learning |
|  | [ ]  State Agency | [ ]  Community-Based Organization | [ ]  Hospital |
|  | [ ]  Indian Tribe | [ ]  Minority-Owned Business | [ ]  Private |
|  | [ ]  Faith-Based Nonprofit\*  | [ ]  Other:       |  |
|  | *\*If incorporated, provide the ten-digit charter number assigned by the Secretary of State:* |       |
| 9. | Proposed Budget Period | Start | 09/01/25 | End | 08/31/26 |
| 10. | Counties Served by Project |       |
| 11. | Amount of Funding Requested |       |
| 12. | Projected Expenditures | Will the respondent’s projected federal and state expenditures exceed $1,000,000 for their current fiscal year?\* |
|  |  | [ ]  Yes [ ]  No*\*Projected expenditures should include anticipated expenditures under all federal grants, including pass-through federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.* |
| 13. | Project Contact Person | Name |       |
|  |  | Title |       |
|  |  | Email |       |
|  |  | Phone |       |
|  |  | Fax |       |
| 14. | Financial Officer | Name |       |
|  |  | Title |       |
|  |  | Email |       |
|  |  | Phone |       |
|  |  | Fax |       |
| I affirm that all information herein is accurate. I confirm that the respondent will fulfill the role of an Administrative Agency, as established in Appendix A: Program Requirements for Service Delivery and Administrative Contracts. I understand that initiating and continuing a contractual relationship with DSHS requires compliance with the assurances and certifications in the competitive request for proposal, the original contract, and any subsequent renewals or amendments. The respondent’s governing body has approved this application, and I have authorization to sign it on their behalf. |
| 15. | Authorized Representative | Name |       |
|  |  | Title |       |
|  |  | Email |       |
|  |  | Phone |       |
|  |  | Fax |       |
|  |  |  |
| 16. | Authorized Representative Signature |       | 17. Date |       |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Form A Instructions** |
| This form provides basic information about the applicant and the proposed project, including the signature of the authorized representative. It is the cover page of the request for proposal 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 identified Competitive Request for Proposal. Applicant 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 response.  |
|  |
| 1. | **Legal Business Name:** Enter the applicant’s legal name. |
| 2. | **Physical Address:** Enter the applicant’s complete physical address, city, county, state, and 9-digit zip code. |
| 3. | **Mailing Address:** Enter the applicant’s complete mailing address, city, county, state, and 9-digit zip code. |
| 4. | **Payee Name:** Enter the name of the entity involved in a contractual relationship with the applicant to receive payment for services rendered and maintain the accounting records for the contract (e.g., fiscal agent). The payee is the corporation, entity, or vendor who will receive payments. |
| 5. | **Payee Mailing Address:** Enter the payee’s complete mailing address, city, county, state, and 9-digit zip code. |
| 6. | **Unique Entity Identification (UEI) Number:** Enter the applicant’s Unique Entity Identification (UEI) number. The UEI is a 12-character alphanumeric value. The applicant must have this number if they receive federal funds and can obtain one at https://sam.gov/content/home.  |
| 7. | **Federal Tax ID, Texas Comptroller Vendor ID, or Social Security Number:** Enter the applicant’s Federal Tax Identification Number, Texas State Comptroller Vendor Identification Number, or Social Security Number (nine, fourteen, or nine digits respectively). The applicant acknowledges, understands, and agrees that using a Social Security number as its contractual vendor identification number may result in the number becoming public via state open records requests. |
| 8. | **Type of Entity:** Check the type of entity as defined by the Secretary of State at [sos.state.tx.us/corp/businessstructure.shtml](http://www.sos.state.tx.us/corp/businessstructure.shtml) or the Texas State Comptroller at [fmx.cpa.texas.gov/fm/pubs/payment/gen\_prov/index.php?s=tins\_codes&p=ownership](https://fmx.cpa.texas.gov/fm/pubs/payment/gen_prov/index.php?s=tins_codes&p=ownership) and check all other boxes that describe the entity.* Historically Underutilized Business is defined in the [Texas Government Code, Title 10, Subtitle D, Chapter 2161](https://statutes.capitol.texas.gov/docs/gv/htm/gv.2161.htm).
* State Agency is defined in the [Texas Government Code, Title 10, Subtitle B, Chapter 2056](https://statutes.capitol.texas.gov/Docs/GV/htm/GV.2056.htm).
* Institution of Higher Education is defined by the [Texas Education Code, Title 3, Subtitle B, Chapter 61](https://statutes.capitol.texas.gov/Docs/ED/htm/ED.61.htm).
* Minority-Owned Business is defined in the [Texas Government Code, Title 10, Subtitle G, Chapter 2306](https://statutes.capitol.texas.gov/Docs/GV/htm/GV.2306.htm).
 |
| 9. | **Proposed Budget Period:** DSHS has entered the budget period for this application for you. |
| 10. | **Counties Served by Project:** Enter the proposed counties served by the project. |
| 11. | **Amount of Funding Requested:** Enter the funding per the allocation given by DSHS for proposed project activities (not including possible renewals). This amount must match Table A, Column 2 above. |
| 12. | **Projected Expenditures:** If the applicant’s projected federal and state expenditures exceed $1,000,000 for their current fiscal year, they must arrange a financial compliance audit (Single Audit). |
| 13. | **Project Contact Person:** Enter the name, title, email address, phone number, and fax number of the person responsible for the proposed project. |
| 14. | **Financial Officer:** Enter the name, title, email address, phone number, and fax number of the person responsible for the financial aspects of the proposed project. |
| 15. | **Authorized Representative:** Enter the name, title, email address, phone number, and fax number of the person authorized to represent the applicant. |
| 16. | **Authorized Representative Signature:** The person authorized to represent the applicant must sign in this blank. |
| 17. | **Date:** Enter the date the authorized representative signed this form. |

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**FORM B: PROPOSAL TABLE OF CONTENTS AND CHECKLIST**

|  |  |
| --- | --- |
| **Legal Name of Applicant:** |        |

|  |  |  |  |
| --- | --- | --- | --- |
| **Section I** | **Included?** | **N/A** | **Page #** |
| Form A: Face Page | [ ]  | [ ]  |       |
| Form B: Proposal of Contents and Checklist (complete and include) | [ ]  | [ ]  |       |
| Form C: Project Sponsor Data Sheet | [ ]  | [ ]  |       |
| Form D: Program Contact Information | [ ]  | [ ]  |       |
| Form E: HOPWA Narrative | [ ]  | [ ]  |       |
| Current/Proposed Agency STRMU Caps (include in Narrative Section if applicable) | [ ]  | [ ]  |       |
| Form F: Line Item and Categorical Budget Justification for HOPWA (excel format) | [ ]  | [ ]  |       |
| Form G: Collaborative Agreement List | [ ]  | [ ]  |       |
| **Section II** |  |  |  |
| **ASSURANCES AND DISCLOSURES FORMS SECTION:** |  |  |  |
| Administrative Information (complete and/or include documentation) | [ ]  | [ ]  |       |
| Nonprofit Board of Directors and Executive Director Assurances Form  | [ ]  | [ ]  |       |
| HIV Contractor Assurances Form | [ ]  | [ ]  |       |
| **REQUIRED ATTACHMENTS:** |
| 1. Board of Directors List | [ ]  | [ ]  |       |
| 2. Board of Directors Bylaws | [ ]  | [ ]  |       |
| 3. Articles of Incorporation | [ ]  | [ ]  |       |
| 4. IRS Non-Profit Determination Letter | [ ]  | [ ]  |       |
| 5. Current Financial Audit in accordance with the OMB Circular A-133 or most recent financial audit | [ ]  | [ ]  |       |

**Form C: HOPWA Project Sponsor Data Sheet**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 09/01/25 – 08/31/26

|  |
| --- |
| The Administrative Agency must complete one Data Sheet for each Project Sponsor in each HSDA. Electronically submit Data Sheets to the HOPWA Coordinator before the program year begins (09/01). Form A certifies all information herein is true.  |
| Administrative Agency |       |
| Project Sponsor Name |       |
| Project Sponsor Parent Company Name |       |
| Selection Process for Project Sponsor | Choose a selection process. | If other:       |
| Is System for Award Management (SAM) registration active? | Yes or No |
| Unique Entity Identification (UEI) Number |       |
| Employer ID Number (EIN) or Tax ID Number (TIN) |       |
| North American Industry Classification System (NAICS) Code |       |
| HIV Service Delivery Area (HSDA) | Choose an HSDA. |
| Physical Address |       |
| Mailing Address |       |
| Main Phone Number |       |
| Main Fax Number |       |
| Website |       |
| Facebook Page |       |
| Twitter Handle |       |
| What department administers the HOPWA grant? |       |
| Is this a nonprofit organization? | Yes or No |
| Is this a faith-based organization? | Yes or No |
| Is this a grassroots organization? | Yes or No |
| Cities in this HSDA |       |
| Counties in this HSDA |       |
| Congressional Districts in this HSDA |       |
| Congressional District of Project Sponsor |       |
| **Assurances and Certifications** |
| This Project Sponsor complies with all federal and state regulations, policies, procedures, standards, general provisions, and guidelines as specified in their subcontract, the Texas Health and Human Services Uniform Terms and Conditions, and the DSHS HOPWA Program Manual. The Administrative Agency’s procurement and oversight procedures for this Project Sponsor follow the minimum standards required by 2 CFR §200 et seq.* DSHS has not suspended this Project Sponsor from future contracts nor terminated a prior contract with them for cause.
* This Project Sponsor has not defaulted on any repayment agreements with DSHS.
* This Project Sponsor has not had a contractually required license or certification revoked.
* This Project Sponsor has not voluntarily surrendered any DSHS-issued license within the past three years.
* The Administrative Agency followed written procurement policies and procedures to advertise and award these funds.
* The Administrative Agency executed a written subcontract with the Project Sponsor consistent with the DSHS contract.
* The Administrative Agency will bear responsibility to DSHS for this Project Sponsor’s performance.
* The Administrative Agency will follow written monitoring policies and procedures to conduct programmatic and fiscal monitoring of this Project Sponsor. They will provide this Project Sponsor and DSHS with written reports of the results. They will take appropriate corrective actions if this Project Sponsor breaches contract terms. They will maintain documentation of monitoring plans and activities pertaining to this Project Sponsor for future review.
* The Administrative Agency will submit documentation of this Project Sponsor’s actual or potential conflicts of interest for review and disposition by DSHS within ten days of the date they became aware of the conflict.
 |
| **Activity** | **Allocation** | **Households to be served:** |
| Tenant-Based Rental Assistance | $ |       |       |
| Short-Term Rent, Mortgage, Utility | $ |       |       |
| Facility-Based Housing Assistance | $ |       |       |
| Permanent Housing Placement | $ |       |       |
| Housing Case Management | $ |       |       |
| Housing Information Services | $ |       |       |
| Resource Identification | $ |       |  |
| Project Sponsor Administration | $ |       |  |
| **Total** | **$** |  |  |

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**FORM D: PROJECT SPONSOR CONTACT INFORMATION**

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| This form provides information about the appropriate program contacts in the applicant’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 notify the Administrative Agency in writing. |
| Legal Applicant Name:  |       |
| **Executive Director:** |       |
| Title: |       |
| Email: |       |
| Phone: |       |
| Fax: |       |
| Mailing Address: |       |
| **Project Contact:** |       |
| Title: |       |
| Email: |       |
| Phone: |       |
| Fax: |       |
| Mailing Address: |       |
| **Financial Reporting Contact:** |       |
| Title: |       |
| Email: |       |
| Phone: |       |
| Fax: |       |
| Mailing Address: |       |
| **Grants Management Contact:** |       |
| Title: |       |
| Email: |       |
| Phone: |       |
| Fax: |       |
| Mailing Address: |       |
| **Data Management Contact:** |       |
| Title: |       |
| Email: |       |
| Phone: |       |
| Fax: |       |
| Mailing Address: |       |
| **HOPWA Contact (if different from Project Contact:** |       |
| Title: |       |
| Email: |       |
| Phone: |       |
| Fax: |       |
| Mailing Address: |       |

**FORM E: HOPWA NARRATIVE**

Applicant shall describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments. Address the required elements associated with the services proposed in this RFP application. **This narrative section should not exceed a maximum of 15 pages.**

***Answer the following questions:***

**Statement of Intent**

1. What is the Applicant’s mission statement? How does offering HOPWA fit with the Applicant’s mission statement?

**Applicant’s Experience**

1. Briefly describe delivery systems policies, support systems (i.e., training, research, technical assistance, information, financial and administrative systems) and other infrastructure available to achieve service delivery and policy-making activities. Answer the following question: “What resources do we have to perform the project, who will deliver the services. and how will they be delivered including specifics of how clients will access services?”
2. Describe the Applicant’s experience with financial management. Include information on the following: Financial controls, Board of Directors involvement in the financial controls; managing multiple budgets; financial Infrastructure (staffing) and managing grant funds.
3. Describe the Applicant’s experience managing client-level data in the following areas:
	1. Handling and protecting PHI.
	2. Ensuring the accuracy and completeness of data.
	3. Ensuring the promptness of data entry; Collecting and managing relevant data for documenting services and reporting.
	4. Describe how your agency will collect and tabulate HOPWA data correctly.
	5. Describe the process for conducting quality assurance on the collected data.
	6. Identify who will be responsible for data collection and reporting this information to the AA. Please provide this person’s qualifications and experience.

**Service Delivery**

1. Summarize the housing needs and all available housing resources in the proposed service area.
2. Describe delivery systems and summarize the proposed services, population to be served, number of clients to be served, location (counties to be served), etc. Include the following chart with your detailed narrative response:

|  |  |
| --- | --- |
| ***HOPWA Funded Services*** | ***Target Unduplicated Households*** |
| * 1. Number of households to receive TBRA
 | *Indicate* ***NA*** *if not applicable* |
| * 1. Number of households to receive STRMU
 |  |
| * 1. Number of households to receive PHP
 |  |
| * 1. Number of households to receive HOPWA-funded Supportive Services (Housing Case Management)
 |  |

7. Describe your agency’s outreach plan to ensure access to HOPWA services. Describe in detail your methods of outreach (process used in discovering and acquainting new clients with services) used in the areas/populations to be served. Describe the process used to reconnect clients identified through your agency’s outreach into medical care if they are not in care.

1. Describe applicant’ relationship to other organizations within the HIV Service Delivery Area. Specifically address linkages to health and social service agencies, including those that serve people with HIV/AIDS and area housing authorities. Describe your plan to make certain HOPWA will be the payer of last resort and how duplication of services will be avoided. Also describe how the applicant will ensure households access other affordable housing opportunities such as the Housing Choice Voucher Program. (Complete Form H Collaborative Agreement)
2. If the applicant is proposing to impose annual CAPS (i.e., STRMU CAP), please describe the proposed CAP and detail how the process will be uniform, consistent and non-discriminatory. (Please note all CAPS must be approved prior to implementation by AA and DSHS. This is a description of proposed CAP only; approval of the RFP is not an approval for the proposed CAP). *This response is not included in the maximum page limit, Cap justification is a maximum of two (2) additional pages.* ***If not applicable, please skip***.

*Address each prompt in the order listed. Please indicate each corresponding prompt number/letters on the submitted narrative response. A maximum of (15) pages may be attached.*

**ALL NARRATIVE RESPONSES SHOULD BE INSERTED HERE**

**FORM F: CATEGORICAL BUDGET INSTRUCTIONS**

|  |
| --- |
| Please submit a twelve-month line item and categorical budget and justification for this contract term based on the total allocation in Appendix A (see the attached categorical budget template in Excel format). Submit your budget in whole dollars only. Please insert into the appropriate order in your completed RFP. ***No other format will be accepted for the Categorical Budget Justification.*** |
| **The categorical budget must clearly summarize the dollar amounts allocated to the following HOPWA activity categories:** |
| O55 | Tenant-Based Rental Assistance |
| O55 | Short-Term Rent, Mortgage, and Utility |
| O55 | Permanent Housing Placement |
| O55 | Housing Case Management |
| O55 | Project Sponsor Administration |

FORM G: Collaborative Agreements with Other Service Providers Form

Project Sponsors must establish linkages and collaborative relationships with local Housing Choice Voucher Programs (HCVPs) and other affordable housing programs. Specifically list all collaborative agreements (i.e., shared resources, facilities, staff, etc.) with other agencies which are a component of the delivery of the proposed service category. ***Definition of collaboration****: Two or more separate entities that have a formal written agreement to work together in a cooperative effort toward specific and agreed upon objectives. These usually involve shared staff, facilities, other resources, or subcontracts*. (**Make additional copies of the form, as necessary**)

|  |
| --- |
| Collaborative Agreements/Community Collaborations |
| List Collaborating AgencyName and Street Address | Specific services that collaborative agency will provide to clients in this collaboration | Specific services that applicant will provide to clients in this collaboration |
|  |  |  |
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Assurances and Disclosures

**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 and/****or provide the required supplemental document behind this form.*** *If responses require multiple pages, identify the supporting pages/documentation with the applicable request. If approved, the applicant may be required to submit proof of affirmative answers.*

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

|  |  |
| --- | --- |
| **Legal Name of Respondent:** |       |

**Identifying Information**

|  |  |
| --- | --- |
| **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 Corporation*** 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 corporation.
 |
|  |  |
| **2.** | **Is respondent a private, nonprofit organization?** |
|  |  |
|  |  | [ ]  | **YES** | [ ]  | **NO** |  |
|  |  |
|  | *If YES, respondent must include evidence of its nonprofit status with the proposal. Any one of the following is acceptable evidence. Check the appropriate box for the attached evidence or complete the “Previously Filed” section, whichever is applicable.* |

|  |  |  |
| --- | --- | --- |
|  | [ ]  | (a) A reference to the organization’s listing in the Internal Revenue Service’s (IRS’s) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code. |
|  |  |  |
|  | [ ]  | (b) A copy of a currently valid IRS exemption certificate. |
|  |  |  |
|  | [ ]  | (c) 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. |
|  |  |  |
|  | [ ]  | (d) A certified copy of the organization’s certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization. |
|  |  |  |
|  | [ ]  | (e) 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 RFP. Examples of potential conflicts include an existing or potential business or personal relationship between the respondent, its principal, or any affiliate or subcontractor, with TRG, DSHS, the Health and Human Services Commission, or any other entity or person involved in any way in any project that is the subject of this RFP. Similarly, any existing or potential personal or business relationship between the respondent, the principals, or any affiliate or subcontractor, with any employee of TRG, DSHS, or 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 proposal. If following a review of this information, it is determined by TRG 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 RFP if the bid includes financial participation with the respondent by a person who received compensation from DSHS to participate in preparing the specifications or the RFP on which the bid is based.

|  |  |
| --- | --- |
| **1.** | **Does anyone in the respondent organization have an existing or potential conflict of interest relative to the performance of the requirements of this RFP?** |
|  |  |
|  |  | [ ]  | **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.)* |

|  |  |
| --- | --- |
| **2.** | **Has any member of respondent’s executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the proposal due date?** |
|  |  |
|  |  | [ ]  | **YES** | [ ]  | **NO** |  |
|  |  |
|  | *If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation*. |

|  |  |
| --- | --- |
| **3.** | **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.)* |

|  |  |
| --- | --- |
| **4.** | **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.*  |

**Additional Information for Non-Profit Agencies**

Non-profit applicants must be able to demonstrate fiscal solvency. Applicants shall submit a copy of the organization’s most recent audited balance sheet with management letters and audit notes, and a statement of income and expenses. If the applicant does not have an audited balance sheet and statement of income and expenses, the applicant must attach the most recent unaudited balance sheet and statement of income and expenses and explain why audited documents are not available (***Attach no more than one additional page***). TRG will evaluate the financial statements and may, at its sole discretion, reject the proposal on the grounds of the applicant’s financial capability. (***Financial documentation is only required once per application***)

|  |  |
| --- | --- |
| 1. | Are required financial statements attached? |
|  |  | [ ]  | YES | [ ]  | NO |  |

|  |  |
| --- | --- |
| 2. | Does the applicant have personnel policies approved by the governing body which address essential issues of personnel management? |
|  |  | [ ]  | YES | [ ]  | NO |  |

|  |  |
| --- | --- |
| 3. | Does the applicant contract with or employ the services of a CPA, accountant, bookkeeping service or trained financial manager other than the Executive Director? |
|  |  | [ ]  | YES | [ ]  | NO |  |

If the applicant is a nonprofit entity, respond to the following:

|  |  |
| --- | --- |
| a. | Applicant has an active, involved board as demonstrated by bylaws, regular meetings with sufficient attendance, minutes, and clear definition of role? |
|  |  | [ ]  | YES | [ ]  | NO |  |

|  |  |
| --- | --- |
| b. | Board membership includes diverse community representation? |
|  |  | [ ]  | YES | [ ]  | NO |  |

|  |  |
| --- | --- |
| c. | Board membership includes diverse skills? |
|  |  | [ ]  | YES | [ ]  | NO |  |

|  |  |
| --- | --- |
| d. | Applicant maintains Directors and Officers insurance? |
|  |  | [ ]  | YES | [ ]  | NO |  |

|  |  |
| --- | --- |
| e. | Applicant has a Board policy and procedures manual? |
|  |  | [ ]  | YES | [ ]  | NO |  |

|  |  |
| --- | --- |
| f. | Applicant provides orientation and training on board member responsibilities to new members? |
|  |  | [ ]  | YES | [ ]  | NO |  |

g. What date did the applicant’s Board of Directors adopt the current operating budget of the agency?

|  |  |
| --- | --- |
| h. | Applicant must attach a copy of the Board minutes for the meeting in which the operating budget was adopted. Are the minutes attached? |
|  |  | [ ]  | YES | [ ]  | NO |  |

|  |  |
| --- | --- |
| Signature of Authorized Official | Title |
| Typed Name of Authorized Representative | Date |

**NONPROFIT BOARD OF DIRECTORS AND EXECUTIVE DIRECTOR ASSURANCES FORM**

If the applicant is a nonprofit organization, this form must be completed (state or other governmental agencies are not required to complete this form). The purpose of the form is to inform nonprofit board members and officers of the responsibilities and administrative oversight requirements of nonprofit applicants intending to or contracting with Department of State Health Services (DSHS).

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(Name & Address of Organization)

The person signing on behalf of the above named organization certifies that they are duly authorized to sign this Assurances form on behalf of the organization. The undersigned acknowledge and affirm:

A. That an annual budget has been approved for each contract with DSHS.

B. The Board of Directors convenes on a regularly scheduled basis (no less than quarterly) to discuss the operations of the organization.

C. Actual revenue and expenses are compared with the approved budget, variances are noted, and corrective action taken as needed (with Board approval).

D. Timely and accurate financial statements are presented by the designated financial officer on a regular basis to the board.

E. That the Board of Directors will ensure that any required financial reports and forms, whether federal or state, are filed on a current and timely basis.

F. Adequate internal controls are in place to ensure fiscal integrity and accountability and to safeguard assets.

G. The Treasurer of the Board has been fully informed of his or her responsibilities as Treasurer.

H. The Board has Audit and/or Finance Committees that convene regularly and communicate effectively with the Board Treasurer and other Board members in understanding and responding to financial developments.

I. The organization observes Generally Accepted Accounting Principles when preparing financial statements and fund accounting practices are observed to ensure integrity among specific contracts or grants.

J. If a contract is executed with DSHS, this form will be discussed in detail at the next official Board meeting and that notes of the discussion and a signed copy of this form will be included in the minutes of the meeting. A copy of the minutes will be kept at the organization and be available for inspection by TRG and/or DSHS staff.

* + 1. If a contract is executed with the DSHS and the nonprofit organization has not received any funding from DSHS for the past 24 months, the Legal and Fiscal Responsibilities for Nonprofit Board of Directors Video and Guide will be viewed and a signed “tear-out” sheet will be completed and filed by each board member with the nonprofit organization no later than 45 days after contract execution. Newly appointed/elected board members will comply with these requirements no more than 45 days after taking office. All tear-out sheets will be available for inspection by DSHS staff.
		2. The organization will administer any contract executed with the DSHS in accordance with applicable federal statutes and regulations, including federal grant requirements applicable to funding sources, Uniform Grant Management Standards issued by the Governor’s Office, applicable Office of Management and Budget Circulars, applicable Code of Federal Regulations, and provisions of the contract document.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **\*Chairman of the Board Signature/Date** |  | **\*President or Executive Director Signature/Date** |

**Texas Department of State Health Services**

**HIV/STD Prevention and Care Branch**

**Houston Regional HIV/AIDS Resource Group, Inc.**

HIVCONTRACTOR ASSURANCES

1. ADVOCATE AND PROMOTE

The applicant agency assures that it does not advocate or promote conduct that violates state law, in compliance with the HIV Services Act, Texas Health and Safety Code, Section 85.011, as follows:

"Grants may not be awarded to an entity or community organization that advocates or promotes conduct that violates state law. This subsection does not prohibit the award of a grant to an entity or community organization that provides accurate information about ways to reduce the risk of exposure to or transmission of HIV."

2. CONFIDENTIALITY

The applicant agency and its employees or subcontractors, if applicable, provide assurance to the

Department of State Health Services that confidentiality of all records shall be maintained. No

information obtained in connection with the examination, care, or provision of programs or

services to any person with HIV shall be disclosed without the individual's consent, except as

may be required by law, such as for the reporting of communicable diseases. Information may be

disclosed in statistical or other summary form, but only if the identity of the individuals diagnosed

or provided care is not disclosed.

We are aware that the Health and Safety Code, §81.103, provides for both civil and criminal

penalties against anyone who violates the confidentiality of persons protected under the law.

Furthermore, all employees and volunteers who provide direct client care services or handle

direct care records wherein they may be informed of a client's HIV status or any other information

related to the client's care, are required to sign a statement of confidentiality assuring compliance

with the law. An entity that does not adopt a confidentiality policy as required by law is not

eligible to receive state funds until the policy is developed and implemented.

3. CONFLICT OF INTEREST

The applicant agency and its employees or subcontractors, if applicable, provide assurance to the Department of State Health Services that no person who is an employee, agent, consultant, officer, board member, or elected or appointed official of this agency, and, therefore, in a position to obtain a financial interest or benefit from an activity, or an interest in any contract, subcontract, or agreement with respect thereto, or the proceeds there under, either for himself or herself or for those with whom he or she has family or business ties, during his or her tenure or for one year thereafter shall participate in the decision making process or use inside information with regard to such activity. Furthermore, this agency will adopt procedural rules which require the affected person to withdraw from his or her functions and responsibilities or the decision-making process with respect to the specific assisted activity from which they would derive benefit.

4. TUBERCULOSIS COLLABORATION

The applicant agency assures the DSHS that it maintains collaborative efforts with local Tuberculosis (TB) Control programs in order to insure that HIV and TB treatment and prevention services are provided to persons at risk of HIV and TB.

5. DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing a drug-free awareness program to inform employees about-

1. The dangers of drug abuse in the workplace;
2. The grantee's policy of maintaining a drug-free workplace;
	* + 1. Any available drug counseling, rehabilitation, and employee assistance programs; and

(c) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

1. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
2. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will:
3. Abide by the terms of the statement; and
4. Notify the employer of any criminal drug statute conviction for a
5. violation occurring in the workplace no later than five days after such conviction;

(d) Notifying the agency within ten days after receiving notice under subparagraph (d)(2), above, from an employee or otherwise receiving actual notice of such conviction;

(e) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), above, with respect to any employee who is so convicted:

1. Taking appropriate personnel action against such an employee, up to and including termination; or

2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(f) Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f), above.

6. POLICIES OF THE HIV/STD PREVENTION AND CARE BRANCH

|  |  |
| --- | --- |
| Signature of Authorized Certifying Official |  Title |
| Date |
| Legal Name of Applicant Organization |  |

The applicant agency assures the DSHS that it will abide by all policies of the HIV/STD Prevention and Care Branch that apply to the programs being provided. A list of policies applicable to all HIV and STD contractors is provided at: <http://www.dshs.state.tx.us/hivstd/policy/policies.shtm> .

**APPLICANT REQUIRED ATTACHMENTS**

(Please Attach Your Most Current Copy)

Attachment 1: Board of Directors List identifying officers, addresses, emails, phone numbers and occupations.

Attachment 2: Board of Directors By-Laws

Attachment 3: Articles of Incorporation

Attachment 4: IRS Non-Profit Determination Letter

Attachment 5: Current Financial Audit in accordance with the OMB Circular A-133 or most recent financial audit.