



Area Agency on Aging of Southeast Texas
Direct Purchase of Services
October 1, 2020 - September 30, 2021
Vendor Application



PLEASE TYPE OR CLEARLY PRINT APPLICATION INFORMATION

Vendor Name/Legal Entity

DBA (if applicable)

Physical Address

Mailing Address

Phone Number

Fax Number

Tax Identification Number (SSN or Federal ID):

Type of Provider(Please Check ✓ Applicable):

- City Government Private Non-Profit Private For Profit
 County Government Other _____

Authorizing Official:	Title:
Email Address:	Telephone:
Is Agency designated as a Historically Underutilized Business? (Attach documentation) _____ Yes _____ No	Is Agency designated as a Minority Owned Business? (Attach documentation) _____ Yes _____ No
Number of Years Organization has been in business:	Is Agency Bonded (Attach certificate): _____ Yes _____ No
Has anyone involved in direct provision of client services been convicted of a felony? _____ Yes _____ No	If yes, explain:
Does organization have liability insurance? (Attach certificate of all insurances) _____ Yes _____ No	Attach a copy of all applicable State and Federal license and /or certifications that regulate your business.

Conflicts of Interest: Attach information of applicable names and relationship of any employee(s) or officers of your organization that may have a conflict of interest with an Area Agency on Aging of Southeast Texas staff person or Advisory Council member.

Service and Bidding/Cost Information

1. Proposed Service: _____

A. Service Area: _____

B. Proposed AAA Cost per Unit: _____ Standard Cost per Unit: _____

2. Proposed Service: _____

A. Service Area: _____

B. Proposed AAA Cost per Unit: _____ Standard Cost per Unit: _____

3. Proposed Service: _____

A. Service Area: _____

B. Proposed AAA Cost per Unit: _____ Standard Cost per Unit: _____

4. Proposed Service: _____

A. Service Area: _____

B. Proposed AAA Cost per Unit: _____ Standard Cost per Unit: _____

5. Proposed Service: _____

A. Service Area: _____

B. Proposed AAA Cost per Unit: _____ Standard Cost per Unit: _____

NOTE: See attached service and unit definition(s) for specific service and unit information. If any rate listed above is higher than those normally charged to DHS-eligible seniors or to other agencies, please attach a thorough explanation for the rate difference. If your agency contracts with another Area Agency on Aging and the above rate is higher than the current rate given to that Area Agency on Aging of Southeast Texas, attach a thorough explanation for the rate difference.

Documentation of Standard Fees such as a fee schedule or certification of cost is required for organizations proposing to provide services at reduced rates. The Area Agency on Aging reports the difference in rates as program match.

Service Availability

Days of the Week Available:
Hours Available:
Advance Notice Desired:
Holidays Observed:
Describe any restrictions or limitations on the availability of service such as eligibility criteria, geographic limitations, minimum/maximum number of service units:
Specify names and skill levels of all bi-lingual staff:

Additional Required Attachment:

- A. Authorized Signature Page
- B. Historically Underutilized Business Documentation (if applicable)
- C. Minority Owned Business Documentation (if applicable)
- D. Liability and other Insurance Proof (Documentation)
- E. All License and Certification Documentation (if applicable)
- F. Bond Certificate (if applicable)

SIGNATURE PAGE

As Chairperson/Proprietor, I certify that the information contained in this application is true and fairly represents the organization and its proposed unit cost for the specified project. I acknowledge that I have read and understood the requirements and provisions in this vendor request and the Agency is prepared to implement the program as specified in this application.



Chair / Proprietor's Name (Printed or Typed Name)

Title



X _____
Authorized Signature

Date

Area Agency on Aging of Southeast Texas
Authorized Signature Form for Request for Payment
Direct Purchase of Services Vendor

Name and Address of Vendor Agency:

Individuals Authorized to sign Vendor Agreement and/or Vendor Invoice:

VENDOR AGREEMENT	VENDOR AGREEMENT
_____	_____
Typed Name, Title (Above Line)	Typed Name, Title (Above Line)
_____	_____
Signature	Signature

VENDOR INVOICES	VENDOR INVOICES
_____	_____
Typed Name, Title (Above Line)	Typed Name, Title (Above Line)
_____	_____
Signature	Signature

Name of Contacts at your Agency

NAME OF VENDOR EMPLOYEE COORDINATING LINKAGE CLIENTS	NAME OF BILLING CONTACT PERSON
_____	_____
Name	Name
_____	_____
Email address	Email address
_____	_____
Phone	Phone
_____	_____
Fax Number	Fax Number

I certify that the signatures above are of the individuals authorized to sign for Vendor Agreement and/or Vendor Invoice.

_____ **X** _____

Printed or Typed Name and Title of Authorized Official **Signature and Date**