

**APPLICATION FOR
FEDERAL ASSISTANCE**

1. TYPE OF SUBMISSION: <i>Application</i> <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		<i>Preapplication</i> <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction		2. DATE SUBMITTED 5/15/2014	Applicant Identifier									
				3. DATE RECEIVED BY STATE	State Application Identifier									
				4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier									
5. APPLICANT INFORMATION														
Legal Name: TMC			Organizational Unit:											
Organizational DUNS: 10527414			Department: HHS: Office of HeadStart											
Address: Street: 5215 McPherson Rd.			Division: HHS: Office of HeadStart											
City: Laredo			Name and telephone number of person to be contacted on matters involving this application											
County: Webb			Prefix: _____ First Name: John											
State: Texas Zip Code: 78041			Middle Name: _____											
Country: United States			Last Name: Gonzales											
6. EMPLOYER IDENTIFICATION NUMBER (EIN): <table border="1"><tr><td>7</td><td>4</td><td>1</td><td>6</td><td>9</td><td>5</td><td>4</td><td>6</td><td>0</td></tr></table>			7	4	1	6	9	5	4	6	0	Suffix: _____		
7	4	1	6	9	5	4	6	0						
			E-mail: john.gonzales@mail.tmccentral.org											
			Phone Number (give area code): 956-722-5174		Fax Number (give area code): 956-725-0907									
7. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision			7. TYPE OF APPLICANT: (See back of form for Allocation Types)											
If Revision, enter appropriate letter(s) in box (es) (See back of form for description of letters.) <input type="checkbox"/> <input type="checkbox"/>			Other (specify) Non-Profit											
Other (Specify) _____			9. NAME OF FEDERAL AGENCY: DHHS, ACF, OHS											
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: <table border="1"><tr><td>9</td><td>3</td><td>6</td><td>0</td><td>0</td></tr></table> Early Head Start			9	3	6	0	0	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Early Head Start						
9	3	6	0	0										
12. AREAS AFFECTED BY PROJECT (cities, counties, states, etc.) Webb County			14. CONGRESSIONAL DISTRICTS OF: _____											
13. PROPOSED PROJECT: Start Date: 09/01/2014 Ending Date: 8/31/2015			a. Applicant: 28 b. Project: _____											
15. ESTIMATED FUNDING:			16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?											
a. Federal	\$	202,974.00	A YES THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON											
b. Applicant	\$.00	DATE: _____											
c. State	\$.00	B NO <input type="checkbox"/> PROGRAM IS NOT COVERED BY E O 12372											
d. Local	\$.00	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW											
e. Other (Local match)	\$	50,744.00												
f. Program Income	\$.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?											
g. TOTAL	\$	253,718.00	<input type="checkbox"/> Yes If "Yes," attach an explanation <input checked="" type="checkbox"/> No											
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.														
a. Typed Name of Authorized Representative														
Prefix: Mr.	First Name: Louis	Middle Name: Daniel												
Last Name: Liskai	Suffix: _____		C. Telephone Number (give area code): 956-722-5174											
Title: Board Chair	Date Signed: 5/15/2014													
Signature of Authorized Representative: <i>Louis D. Liskai</i> <i>by RCH</i>														