



1. Please check the applicable box

Prime: \_\_\_\_\_ Sub-Contractor: \_\_\_\_\_ (This form must be completed by and for each).

2. Name of Firm: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

3. Street Address, City, State, Zip: \_\_\_\_\_

4. Identify Principals/Partners in Firm

Name	Title	% of Ownership

5. Identify the individual(s) who will act as project manager, along with other supervisory personnel on the engagement team working this contract. (Do not duplicate any resumes required above).

Name	Title

6. Diversity Statement: Check all of the following that apply to the ownership of your firm, entering the percentage (%) of ownership for each:

Caucasian American (Male)    
 Public-Held Corporation    
 Government Agency    
 Non-Profit Organization  
\_\_\_\_\_ %     \_\_\_\_\_ %     \_\_\_\_\_ %     \_\_\_\_\_ %

7. Minority – (MBE) or Woman-Owned (WBE) Business Enterprise (Qualifies by virtue of 51% or more ownership and active management by one or more of the following):

African American    
 Native American    
 Hispanic American    
 Asian/Pacific American    
 Hasidic Jew  
\_\_\_\_\_ %     \_\_\_\_\_ %     \_\_\_\_\_ %     \_\_\_\_\_ %     \_\_\_\_\_ %

Asian/Indian American    
 Woman-Owned (MBE)    
 Women Owned (Caucasian)    
 Disabled Veteran    
 Other (Specify)  
\_\_\_\_\_ %     \_\_\_\_\_ %     \_\_\_\_\_ %     \_\_\_\_\_ %     \_\_\_\_\_ %

WMBE Certification Number: \_\_\_\_\_

Certified by (Agency): \_\_\_\_\_

(Note: A certification Number is Note Required)



8. Are you a Section 3 Business Concern: \_\_\_\_\_

For clarification of a Section 3 Business Concern, please refer to TGHA's Website. [www.tgha.net](http://www.tgha.net)

9. Federal Tax ID Number: \_\_\_\_\_

10. South Carolina Business License: \_\_\_\_\_

11. State of \_\_\_\_\_ License Type and Number: \_\_\_\_\_

12. Worker's Compensation Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

13. General Liability Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

14. Professional Liability Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

15. Debarred Statement: Has this firm, or any principal(s) ever been debarred from providing any services by the Federal Government, any government, the State of \_\_\_\_\_, or any local government agency within or out of the State of \_\_\_\_\_? **Yes**  **No**

If "Yes", please attached a full detailed explanation, including dates, circumstances and current status.

16. If your firm currently holds any State of Federal Contracts, please list all contract #s (i.e. CoStar, DGS Contracts, GSA Schedule 70 or 84, US Communities, WSCA, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Would your company be interested in receiving Direct Deposit Payment from the Agency?  
 Yes  No

18. Verification Statement: The undersigned proposer hereby states by completing and submitting this form, he/she verifies that all information provided herein is, to the best of his/her knowledge, true and accurate, and agrees that if the Agency discovers any information entered herein is false, that shall entitle the Agency to not consider nor make award or to cancel any award with the undersigned party.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Company Name