SOUTH CENTRAL LOS ANGELES REGIONAL CENTER
FOR DEVELOPMENTALLY DISABLED PERSONS, INC.

Funded Request For Proposals (RFP) Announcement

Community Placement Plan (CPP)
Fiscal Year 2018-2019

CPP Project #3

MOBILE CRISIS SUPPORT SERVICES

INSTRUCTIONS AND FORMS
Informational Meeting: Monday, April 22, 2019 at 10:00am
Written Proposals Due: Monday, April 29, 2019 at 4:30pm

Grant Award is contingent upon funding by the Department of Developmental Services.

South Central Los Angeles Regional Center
Request for Proposals (RFP) Announcement
2018-19 Community Placement Plan
Project #3

Overview

South Central Los Angeles Regional Center (SCLARC) works collaboratively with the Department of Developmental Services (DDS) to develop mental health intervention and training resources to minimize the possibility of individuals being hospitalized, placed in an IMD facility or admitted to Porterville Developmental Center (PDC).

SCLARC is requesting proposals from qualified parties to develop a Mobile Crisis Support Service (MCSS). The MCSS will provide twenty-four hour emergency crisis intervention services, follow-up services as appropriate and necessary, and behavioral supports training to the individual, family, caregiver, facility and/or day service staff as approved by SCLARC.

The applicant chosen must commit to hiring bilingual (English/Spanish speaking) staff.

Applicant Eligibility and Minimum Requirements

- Applicant must be a licensed clinician or BCBA with a minimum of 3 years of experience in the mental health field providing crisis counseling and/or behavioral intervention services to persons with developmental disabilities who also exhibit assaultive, self-abusive, property destruction and/or suicidal behaviors.
- Applicants' clinical director must be a licensed MFT, LCSW, psychologist, or BCBA and have 3 years of experience providing crisis counseling and/or behavioral intervention services to persons with developmental disabilities who exhibit assaultive, self-abusive, property destruction and/or elopement behaviors. This individual must also have experience completing assessments and treatment plans.
- Applicants' crisis counselors must have a BS/BA degree in psychology, social work, health education or a related field and 3 years of experience working the population targeted in this RFP. Certification as a behavior health technician will be considered in place of the degree requirement.
- Applicants must be in good standing with all regional centers; without any active corrective action plans.
- Applicants must submit a vendor disclosure form which will be submitted to confirm that applicants do not have a Medi-Cal fraud conviction or settlement.
- Failure to provide services for the 5-year minimum will result in repayment of a portion of the original start-up funds. The repayment will be as follows:
    - 1 year of operation- 100%
    - 2 years of operation- 75%
    - 3 years of operation- 50%
    - 4 years of operation- 25%
- **Applicants must be prepared to begin providing direct services to consumers by <u>January 1, 2020.</u>**

Ineligible Applicants

The following agencies or individuals are not eligible:

- The State of California, its officers or its employees;
- A Regional Center, its employees, or their immediate family members;
- State Council members, their employees or their immediate family members;
- Any applicants with a conflict of interest regarding its board members or employees.

Proposal Submission

- The proposal will not be considered for review if it is received after the **April 29, 2019** deadline.
- Five (5) copies of the proposal are due on **April 29, 2018** at **4:30 p.m.**
- The contact person for this project is Evelyn Galindo. Ms. Galindo can be reached at evelyng@sclarc.org.

Timeline

- Request for Proposals Announcement………………………………………… 4/16/19
- Proposal Submission Deadline…………………………………………………… 4/29/19
- Proposal Review, Interviews and Recommendation… …………………… 5/10/19
- Notice of Selection Committee Decision……………………………………… 5/20/19
- Applicant Serves Consumers………………………………………………………… 1/1/2020

Selection Procedures

The proposals will be reviewed, scored and prioritized. Failure to follow RFP guidelines or the submission of incomplete documents will result in rejection. **Scoring** will be as follows:

- Organization Background and Experience………………………………… 20
- Proposal Narrative and Service Description…………………………… 25
- Business Set-up and Implementation Plan……………………………… 20
- Evaluation of Previous Performance (service track record)……….. 20
- Number of Regional Centers currently served and any type of current start-up projects throughout CA …………………………………… 15

  Total………………………………………………………………………………………… 100
- Projected Advance Budget………………………………………………………… Accepted/Not Accepted
- Projected Start-up Budget………………………………………………………… Accepted/Not Accepted

Rights Reservations

- SCLARC reserves the right to reject any or all proposals received as a result of this Request for Proposals or to negotiate separately with any contractor when it is determined to be in the best interest of SCLARC.
- SCLARC reserves the right to select any one of the finalists interviewed regardless of the proposal score.
- SCLARC's decision will be final as it relates to the interpretation of the RFP (Request for Proposals).

Proposal Narrative

1. CPP initial funding fiscal year and project number. (CPP 2018-19, Project #3).

2. Contact Information-name, address, email address and telephone number of applicant of the individual to interface with SCLARC during the proposal review process.
3. Company Information- indicate whether applicant is applying as a corporation, non-profit corporation, a limited partnership, or a limited liability corporation. Include copies of the articles of incorporation and corporation by-laws; certificate of limited partnership and any amendments; or a copy of the limited liability company articles of incorporation and certificate of amendment (if any).
4. Proposal Author- provides names of all parties involved in writing all or parts of the proposal.
5. Project Team- names of partners, key staff members and/or consultants (if known) who will be involved in the implementation of the project. Attached copies of the individuals' resumes.
6. Summary of experience providing mobile crisis support and follow-up services to consumers with mental illness who exhibit severe, aggressive behaviors and/or may be assaultive or suicidal.
7. Summary of applicant's commitment to quality services. This section must address each minimum requirement and include the applicant's "continuous quality improvement plan".
8. List of references- provide letters of reference relevant to experience and other qualifications required to complete this or similar services.
9. List of all vendorizations with SCLARC and any other of the California Regional Centers.
10. List of all previous and current start-up projects or (both grant and unsolicited) with any of the California Regional Centers. Note that this information will be used to confirm that applicant has a track record consistent with established timelines for CPP start-up development.
11. List of services provided to other populations (if applicable).
12. Signed "Use of Start-up Guidelines Certification".

Financial Status

1. Applicant/agency financial statements for the past 3 years, documenting financial stability and assets sufficient to undertake the start-up project.

Program Design: Project #3

1. Philosophy regarding providing services to persons with developmental disabilities.
2. Description of the characteristics of consumers appropriate to receive services from this program.
3. Description of 24-hour mobile crisis intervention services.
4. Description of follow-up/stabilization services provided.
5. Description of training services provided to consumers, families and/or service providers.
6. Description of staff job titles, duties and qualifications.
7. Statement of commitment to preparing and maintaining daily, on-going written consumer notes.
8. Statement of commitment regarding the preparation and maintenance of quarterly reports summarizing consumers served and their current status. Agreement that reports will be signed and dated by the program or clinical director, and submitted to the Regional Center within 30 days of the end of the quarter.
9. Consumer medical emergency procedures.
10. Consumer grievance procedure.
11. A statement confirming that applicant will have bilingual staffing in place and trained by the date the service is scheduled to become operational.
12. Statement that the vendor will maintain current general and professional liability and worker's compensation insurance, and name SCLARC as additional insured.
13. Copy of applicant's Zero Tolerance Policy and training outline.
14. Whistle Blower Policy.
15. Description of orientation and ongoing **training** provided to crisis counselors.

Business Set-up and Implementation Plan

1. Provide an action plan with timelines for the start-up project. Vendor must be ready to provide services by January 1, 2020.

Projected Budgets

1. Provide a projected start-up budget.
2. Provide a project budget outlining how the 25% start-up advance will be used.

MULTI PROGRAM VENDOR DEVELOPMENT QUESTIONNAIRE
To be completed by applicant

Note: Please complete the following questions regarding your involvement with other Regional Centers. List any projects that you (or any company or group of which you are a part) currently are operating, are developing, or are in the planning stages of developing with any Regional Center. If you should begin plans for development with any Regional Center after completing this questionnaire, you must notify each Regional Center with which you are associated. Failure to disclose information related to your association with other Regional Centers could result in withdrawal of your vendor status. (Please attach other sheets)

NAME OF APPLICANT: ____

ADDRESS:____

TELEPHONE: (   )____

List below all programs that you (or groups you are associated with) currently are operating and/or currently in the process of developing.

Type of Program	Your Role/Capacity in the Program	Current Status Year Developed	Regional Center
EXAMPLE:			
Adult Day Program	**Program Director/ 45**	**Active/Developed in 1980**	**SCLARC**

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What grants have you received from any Regional Centers, the Department of Developmental Services, HUD, etc. in the last five years (such as Program Development Funds, Community Placement Program, etc.)? ____
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Please describe any other employment or business commitments you may have.

I hereby certify that the above information accurately represents all of my business interests in the State of California, and I give Regional Center staff authorization to contact any of the above Regional Centers for reference information.

____
Signature

____
Print Name

Date: ____________________

APPLICANT/VENDOR DISCLOSURE STATEMENT

GENERAL INSTRUCTIONS

Every applicant or vendor must complete and submit a current Applicant/Vendor Disclosure Statement, DS 1891 (disclosure statement) as part of a complete application packet for vendorization or upon request of the vendoring regional center. The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.101 for additional definitions.

Overall Authority: Code of Federal Regulations (CFR), Title 42, Part 455; California Code of Regulations, Title 17, Section 54311. Welfare and Institutions Code, Section 4648.12.

Important:

• **IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.**

• ***Parents and consumers of Vouchers, Participant-Directed Services, or Purchase Reimbursements:*** Complete Part 1 on page 2 and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date.

• Failure to disclose complete and accurate information will result in a denial of enrollment and/or may be cause for termination of vendorization.

• Read ***ALL*** instructions when completing the disclosure statement.

• Type or print clearly in ink.

• If applicant or vendor must make corrections, please line through, date, and initial in ink. Do not use correction fluid.

• Answer all questions as of the current date.

• If additional space is needed, attach a sheet referencing the part and question being completed.

• Return this completed statement with the complete application package to the regional center to which you are applying.

Part 1: Identifying Information

A. Specify name of the applicant or vendor, agency, facility or organization, vendor number and service code, business address, and telephone number of applicant or vendor submitting the vendor application.
B. Specify in what capacity the applicant or vendor is doing business. For example: The name of the corporation under which they are doing business. This name must match the license name, if applicable.
C. List the National Provider Identifier, of the applicant or vendor, if any.
D. List the Social Security Number, Date of Birth, and/or the Federal Employer Identification Number (EIN) of the applicant or vendor, if any. Enter Vendor’s nine-digit EIN assigned by the IRS in the following format: XX-XXXXXXX.

• An EIN is used to identify the accounts of employers and certain others who have no employees.

• For more information about an EIN, please check http://www.irs.gov for “Employer Identification Numbers” or “EIN”. Whenever this Disclosure Statement requests an EIN about an individual or entity, it has the same meaning.

E. Check the entity type that best describes the structure of your organization.

Part 2: Ownership and Control Interests. Use the following definitions to identify the individuals you should enter in A, B and C of this section. See 42 CFR 455.101 for additional definitions.

• "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the applicant or vendor. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or vendor;
• "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, agency or business entity;
• "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of the applicant or vendor.
• "Person with an Ownership or Control Interest" means a person or corporation that:
A) Has an ownership interest totaling 5 percent or more in an applicant or vendor;
B) Has an indirect ownership interest equal to 5 percent or more of an applicant or vendor;
C) Has a combination of direct or indirect ownership interests equal to 5 percent or more in an applicant or vendor;
D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or
vendor if that interest equals at least 5 percent of the value of the property or assets of the applicant or vendor;
E) Is an officer or director of an applicant or vendor that is organized as a corporation; or
F) Is a partner in an applicant or vendor that is organized as a partnership.
• "Significant Business Transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of an applicant or vendor's total operating expenses.
• "Subcontractor" means an individual, agency, or organization to which an applicant or vendor has contracted or delegated some of the management functions or responsibilities of providing services.
• "Wholly Owned Supplier" means a supplier whose total ownership interest is held by an applicant or vendor or by a person, persons, or other entity with an ownership or control interest in an applicant or vendor.

Part 3: Excluded Individuals or Entities. ***(See page 3. Must be disclosed, if applicable.)***

"Excluded Individuals or Entities" means those individuals and entities that have been placed on either the U.S. Department of Health and Human Services Office of Inspectors' General (OIG) List of Excluded Individuals/Entities or the Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List of persons, or individuals and entities that have been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid or the Title XX services program, or those individuals and entities that meet the criteria included in Title 17, Section 54311(a)(6).

Title 17, California Code of Regulations, Section 54311(a)(6)
(Criteria for Excluded Individuals or Entities)

The name, title and address of any person(s) who, as applicant or vendor, or who has ownership or control interest in the applicant or vendor, or is an agent, director, members of the board of directors, officer, or managing employee of the applicant or vendor, has within the previous ten years:
(A) Been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or in any connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse; or
(B) Been found liable any civil proceeding for fraud or abuse involving any government program; or
(C) Entered into a settlement in lieu of conviction involving fraud or abuse in any government program.

PLEASE FILL OUT

Part 1. Applicant/Vendor Information

A. Name of applicant or vendor, entity, agency, facility, or organization as reported to IRS:

___

Vendor Number and Service Code:

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Business Address:

___

Telephone number (with area code):

___

B. Name registered with California Secretary of State, if any:

___

C. National Provider Identifier (NPI), if any:

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D. Social Security Number (SSN), Date of Birth (DOB), and/or Federal Employer Identification Number (EIN), if any:

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E. Check the entity type that best describes the structure of the applicant or vendor individual, business entity, agency, facility or organization: Check **only one** box:

□ **Parent or Consumer** ***for Vouchers, Participant-Directed Services, or Purchase Reimbursements*** *(*Complete Part 1 above and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date).
□ **Sole Proprietor (Unincorporated)**
□ **General Partnership** □ **Limited Partnership** □ **Limited Liability Partnership**
□ **Limited Liability Company: State of formation: __________**
□ **Governmental**
□ **Corporation: Corporate number: State incorporated: __________**
□ **Nonprofit – Check One:** □ **Unincorporated Association** □ **Religious/Charitable**
□ **Corporation** □ **Other (specify): ___________**

Part 2. Ownership, indirect ownership, and managing employee interests (If not applicable, please indicate.)

A. List the name(s), title(s), address(es), SSNs, and DOBs of individuals for organizations having direct or indirect ownership interests, and/or managing employees in the applicant/vendor (see instructions for definitions). Also list all members of a group practice. Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

Name	Title	Address	SSN	DOB

B. List those persons named in **'A'** above or **'Part 4. A'** below, that are related to each other as spouse, parent, child, or sibling.

Name	Relationship	Address

C. List the name, address, vendor number and service code, SSN, NPI and/or EIN of any other applicant or vendor in which a person with an ownership or controlling interest in the applicant or vendor also has an ownership or control interest of at least 5 percent or more. For example: Are any owners of the applicant or vendor also owners of Medicare or Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.)

Name	Address	Vendor Number and Service Code	SSN, NPI and/or EIN

Part 3. Excluded Individuals or Entities (If not applicable, please indicate.)

List the name, title, and address of any person, as applicant or vendor, or entity with an ownership or control interest, any agent, director, officer, or managing employee of the applicant or vendor who is an excluded individual or entity, as defined on page 2.

Name	Title	Address

Part 4. Subcontractor (If not applicable, please indicate.)

A. List the name, title, address, SSN, NPI and/or EIN of each person or entity with an ownership or control interest **in any subcontractor** in which the applicant or vendor has direct or indirect ownership of 5 percent or more. State percentage.

Name	Title	Address	Percentage	SSN, NPI and/or EIN

B. List the name, title, address, SSN, NPI and/or EIN of each **subcontractor or wholly owned supplier** in which the applicant or vendor has had any significant business transactions within 5 years of the application or request.

Name	Title	Address	SSN, NPI, and/or EIN

APPLICANT/VENDOR SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become vendored, or if the service provider already is vendored, a termination of its vendorization.

By signing this disclosure statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the vendoring Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

____

Name of Applicant/Vendor or Authorized Representative **Title**

____

Signature **Date**

Recordkeeping and Access to Records

Subject to the provisions of Title 17, California Code of Regulations, Section 54311 and Code of Federal Regulations, Title 42, Part 455.105, an applicant or vendored provider agrees to provide access for the review of any and all ownership disclosure information and/or documentation upon written request by the vendoring regional center, the Department of Developmental Services, the State Medicaid Agency, Department of Health Care Services, any State survey team, the Secretary of the United States Department of Health and Human Services, or any duly authorized representatives of the above named entities.

Privacy Statement

All information requested on the application and the disclosure statement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department of Developmental Services pursuant to 26 USC 6041. This information is required by the authority of Welfare and Institutions Code, Section 4648.12 and Title 17, California Code of Regulations, Section 54311. The consequences of not supplying the mandatory information requested are denial of vendorization as a regional center vendor or termination of vendorization. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or licensing programs in other states.