



SCLARC

South Central Los Angeles
Regional Center

for persons with developmental disabilities, inc.

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

**Funded Request For Proposals (RFP) Announcement
Community Resource Development Plan (CRDP)
Fiscal Year 2019-2020**

CRDP Project #2

Specialized 4-bed Enhanced Behavioral Support Home (EBSH) for Adults

INSTRUCTIONS AND FORMS

Information Meeting: November 7, 2019 at 10:00am

Written Proposals Due: Friday, November 15, 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
2019-20 Community Resource Development Plan (CRDP)
Project #2**

Overview

South Central Los Angeles Regional Center (SCLARC) works collaboratively with the Department of Developmental Services (DDS) to develop community living options for adult consumers. The EBSH exceeds the minimum requirements of a Specialized Residential Facility (SRF) by providing enhanced supports, staffing, and supervision as defined in Section 4684.80 of the Welfare and Institutions Code from the State of California Budget Act of 2014, through Trailer Bill Language SB 856. The EBSH will have a maximum capacity of four (4) individuals, all of whom must have a qualifying Regional Center diagnosis. This home is designed to be a crisis facility with the ability to stabilize adults with challenging needs and to assist in transitioning them to a less restrictive environment.

Project #2 –SCLARC is requesting proposals from interested parties to lease property owned by a Housing Development Organization, and operate a four-bed, adult EBSH designed for individuals in the community, but are at risk for DC placement.

Those targeted for placement include: individuals with forensic involvement; substance abuse; sexually inappropriate behaviors; physically assaultive and verbal aggression; and severe mental health issues. Services will focus on behavioral stabilization to avoid psychiatric hospitalizations. Individuals targeted for this home will need intensive supports and services due to severe psychiatric, emotional, and behavioral challenges.

The rate methodology for an EBSH includes a fixed facility component for residential services and individualized services and supports component based on each client's needs as determined through the individual program plan process. For more information on the rate setting process, please refer to Title 17 Section 59072.

Funding is contingent upon funding from the Department of Developmental Services.

Applicant Eligibility and Minimum Service Requirements

- Applicants must be in good standing. Applicants with a history of deficiencies issued by a licensing agency, corrective actions issued by the regional center or similar actions taken by a placement or oversight agency may not be considered for this development.
- Applicants must have a sound financial status. Financial statements for the past 3 years are required. The applicant must have access to a reserve through-out the development and vendorization process. The reserve amount should be approximately \$30,000.00.
- Applicants must have at least 3 years- experience as a regional center vendor or facility administrator, operating a level 4I or specialized adult residential facility, serving physically assaultive clients with severe mental health issues.
- Applicants must have an identified administrator with a minimum of 3 years-experience working with the target population in a licensed residential setting. This individual must have a current administrator's certificate from Community Care Licensing and have completed the Direct

Support Professional Training year one and two course work (challenge tests cannot be accepted). The individual must also be PCMA, CPI or PRO-ACT certified.

- The administrator must also be one of the following: Registered Behavior Technician, Licensed Psychiatric Technician or Qualified Behavior Modification Professional.
- The administrator must be on duty for a minimum of 20 hours per week per facility.
- The direct care lead staff must have at least one-year prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; and become a Registered Behavior Technician within **60 days** of initial employment or, be either a Licensed Psychiatric Technician or Qualified Behavior Modification Professional.
- All direct care staff must: have at least 6 months prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; become a Registered Behavior Technician within **12 months** of initial employment; or be either a Licensed Psychiatric Technician or A Qualified Behavior Modification Professional. These individuals must also have a high school diploma or equivalent.
- At least one direct care lead staff and one direct care staff must be on duty at all times when a client is under the supervision of the facility staff. Staffing beyond this minimum requirement will be determined by each client's identified individual support needs, per the approved **DS 6024 form**.
- Any direct care staff that have not completed the on-site orientation, but are caring for clients, must be under the direct supervision and observation of a direct care lead staff person who has completed the requirements.
- All staff must be PCMA, PRO-ACT or CPI trained before they are allowed to work with clients in the facility.
- In addition to the on-site orientation, direct care staff must receive a minimum of 16 hours of emergency intervention training, which must include the techniques the EBSH will use to prevent injury and maintain safety regarding clients who are a danger to self or others and must emphasize positive behavioral supports and techniques that are alternatives to physical restraints. This training is in addition to CPI, Pro-Act, or PCMA training.
- The direct care staff may not implement emergency interventions prior to successfully completing the training. Therefore, staffing patterns must ensure that at all times there are enough trained/qualified direct care staff to enable adequate implementation of emergency interventions.
- All direct care staff must receive hands-on training in first aid and CPR by a certified instructor.
- The administrator and all staff persons must be PCMA, PRO-ACT or CPI trained before they are allowed to work with clients in the facility.
- The facility must have a staff BCBA. That individual will provide a minimum of eight hours of services to each client per month. Time spent and a summary of monthly services must be documented in each client's file. None direct service-related duties may include direct care staff training and meetings to review behavioral incidents, SIRs and/or to discuss other issues to determine how best to implement, intervene and mitigate inappropriate behaviors.
- In consultation with the Individual Behavior Supports Team, the regional center may require additional professional, administrative, or direct care staff whenever the regional center determines that additional personnel are needed to provide for the client's health and safety.
- Staffing must be in place on the date the facility becomes operational.
- Direct care staff must also speak the language of all of the clients they support.

- The applicants must have an identified consultant. The type of consultant and scope of duties will be determined during the development process to ensure the most appropriate professional is secured to meet the needs of individuals placed in the facility.
- The applicant must identify mental health and medical clinicians as soon as the location of the property is identified. This includes a neurologist, psychiatrist, and general practitioner.
- The applicant must submit written confirmation that each has admitting privileges at a local hospital.
- Applicant must commit to ensuring that the staff BCBA and/or consultant's input regarding behavioral data is communicated to the psychiatrist.
- The home will be developed in accordance with the requirements of Section 4684.80 - 4684.87 of the Welfare and Institutions Code, Title 17 and Title 22.
- Facility service plan will require certification by the DDS and licensure by Community Care Licensing (CCL) prior to vendorization.
- Facility must install and maintain an operable automatic fire sprinkler system.
- Each client will have their own bedroom, with a full or queen size bed.
- The facility will have video cameras in common areas to account for what transpires between clients and staff. Applicant is required to run the cameras continuously when consumers are in the facility.
- Facility must meet applicable Americans with Disabilities Act (ADA) standards.
- Facility is required to have heating, ventilation, and central air conditioning (HVAC).
- Security concerns may prevent some clients from participating in traditional day program activities. The applicant must be prepared to provide structured activities during hours the client would normally be at a community-based day program.
- Applicants must have a gradual dose reduction plan in place for psychotropic medications.
- Applicants must have a written plan to address all of the compliance requirements associated with the drug Clozaril. This includes contracting with a medical service provider that provides in-home services for the weekly blood monitoring.
- Applicants must agree to a team approach to the facility's development and the client's transition into the community. The transition team **may** include physicians and other clinicians, SDC and Regional Project staff, service coordinators, SDC liaisons, resource developers, housing foundation staff, etc.
- Applicants will be required to ensure that services are in place to address areas or concerns raised by the development/transition team upon each client's arrival in the home.
- SCLARC is responsible for monitoring and evaluating services provided by conducting a quarterly quality assurance visit using the DDS format.
- The regional center is responsible for monitoring and evaluating services at least quarterly face-to-face case management visits with each client, or more frequently if specified in the client's IPP.
- The regional center Qualified Behavior Modification Professional must conduct visits in person, at least monthly to monitor the Individual Behavior Supports Plan objectives, and prepare written documentation on the status of the objectives. At least four of these visits per year must be unannounced.
- A vehicle that can accommodate the transportation needs of the clients must be assigned to the facility. Start-up funds are not available to purchase or lease vehicles.
- The direct care staff must be trained to safely escort clients to their outside services and programs and address behavioral issues that may occur in the van.

- The applicant is **required to accept clients SCLARC identifies for placement**. The applicant must commit to modifying services and supports to address any challenges encountered. Issuing a 30-termination notice is **not** acceptable unless a full ID team meeting is held and the team agrees that the placement is not appropriate, and SCLARC gives approval for the service termination.
- Seclusion shall not be utilized in an Enhanced Behavioral Supports Home.
- **This project will be owned and remodeled by a housing development organization (HDO).**
- Applicant must agree to secure a rental agreement with the non-profit organization.
- All items purchased with start-up funds remain the property of DDS and will be returned to the regional center should the contractor for ongoing services terminate for any reason.
- Failure to provide services for the 5-year minimum will result in a 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 clients by January 1, 2021.**

Applicants Ineligible

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;
- Area Board members, their employees or their immediate family members;
- Any applicants with a conflict of interest with either its board members or employees.

Proposal Submission

- The Proposal will not be considered for review if it is received after the **Friday, November 15, 2019** deadline.
- Three (3) copies of the proposal are due on **Friday, November 15, 2019** at **4:30 p.m.**
- The contact person for this project is Evelyn Galindo. Ms. Galindo can be reached at evelyn@ sclarc.org or at (213) 744-8443.

Timeline

• Request for proposals announcement.....	11/1/2019
• Information meeting/bidder’s conference.....	11/7/2019 at 10:00am
• Proposal submission deadline.....	11/15/2019 at 4:30pm
• Proposal review and selection.....	11/18/19 - 12/2/2019
• Interview of the top candidates.....	12/5/2019
• Executive director review and approval.....	12/6/2019 – 12/9/2019
• Notice of selection committee decision.....	12/2019
• Contracts completed	12/23/2019
• Anticipated implementation of service	1/1/2021

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.....	10
• Financial stability	15
• Proposal narrative and program design.....	25
• Implementation plan.....	10
• Projected advance budget.....	10
• Projected start-up budget.....	10
• Evaluation of previous performance (service track record)	10
• Number and type of current start-up projects throughout CA.....	10
Total.....	100

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 in any manner of interpretation of the RFP (Request for Proposals).

Proposal Narrative

Organization Background and Experience

1. CRDP initial funding fiscal year and project number. (CRDP 2019-20, Project #3).
2. Contact Information-name, address, email address and telephone number of applicants 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- Provide 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 all the individuals’ resumes.
6. Summary of experience providing residential services to client with mental illness who exhibit extremely aggressive behaviors.
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 minimum of three 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 CRDP start-up development.
11. List of services provided to other populations (if applicable).

Financial Status

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

Projected Budgets

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

Program Plan

1. Development of Program Plan: The selected applicant will be required to complete a program plan within ninety (90) days of award of the contract. The plan will need to be approved by both SCLARC and DDS.

Implementation Plan

1. Provide an action plan with timelines for the start-up project. Vendor must be ready to provide services by **January 1, 2021**.

Brief Service Description- Not to exceed ten (10) pages and to include the following:

1. A brief description of your experience in developing the type of project for which you are submitting a proposal.
2. A Mission, Vision and Values Statement.
3. A description of the services that you will provide including specific methods and procedures to be utilized in providing the service and project outcomes for individuals served through this project. Service description must reflect evidence that the applicant has an understanding of the considerations involved in providing clinically appropriate, evidence-based services in the least restrictive manner possible.
 - Address the development of positive behavioral support plans for residents with an emphasis on functional behavioral analysis and evidence-based practices.
 - Provide the close supervision these residents will require with an emphasis on mitigating risk to the community, the individual, other residents, and to staff.
 - Address education and treatment approaches for possible substance abuse issues presented by the individuals who will utilize these resources.
 - Teach social skills to assist the individual in learning pro-social behaviors as alternatives to physical aggressive or assaultive behaviors.
 - Systematically address resident motivation issues through the use of incentive systems to promote cooperation and participation in the treatment and educational aspects of the services.
 - Describe how psychiatric needs of individuals will be addressed through therapy, and how staff will be trained to recognize, support, document and report symptoms of psychiatric conditions and medication effectiveness.

4. Staff Recruitment and Retention: Describe your plan to recruit, and retain quality staff. Include:

- Desired characteristics for all staff positions.
- Staffing procedures to mitigate staff burnout and provide staff support in stressful work environments.
- Health and criminal background screening procedures.
- Initial and ongoing training, including required certifications. Include any specialized training for providing behavior support and crisis intervention to individuals who have potentially dangerous behaviors.

5. Continuous Quality Improvement (CQI) System: Describe your agency approach to quality assurance to include:

- How the service agency will use data, such as agency outcomes, stakeholder satisfaction, or other existing data (e.g. incident reports, medication logs) to identify service problems pursuant to corrective changes such as revised staff training curriculums, staff training procedures (e.g. supervision, medication management, recruiting, etc.)
- How processes such as methods and procedures are examined for revision when problem patterns emerge.
- Explain the role of consultants in the quality assurance process.

6. Schedule of Development: The schedule is a step-by-step action plan which includes measurable, time-limited activities by which to develop the proposed service or facility. The project objectives should be realistically achievable within the time frames.

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: _____

NAME OF ORGANIZATION: _____

ADDRESS: _____

TELEPHONE: () _____

EMAIL: _____

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

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.)? _____

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, program 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, program director , 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, program, or organization as reported to IRS:

Vendor Number and Service Code:

Business Address:

Telephone number (with area code):

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

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

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

E. Check the entity type that best describes the structure of the applicant or vendor individual, business entity, agency, program 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

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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.

CONFLICT OF INTEREST DECLARATION

Current service providers and applicants for vendorization are required to report any conflict or potential conflict of interest to the regional center. Pursuant to Title 17, Section 54522, a conflict of interest exists when a regional center employee or the family member of an employee, holds a position as owner, manager or employee in any business entity vendored by a California Regional Center or Department of Developmental Services.

This regulation is in place to ensure that the actions and interests of regional center employees do not have a material financial effect on:

- Any vendored program/service in which the employee or the family member of an employee has a direct or indirect investment.
- Any real property or possession of the vendor in which the employee has a direct or indirect interest.
- Any income received by or promised to the regional center employee as a part of the vendorization process or ongoing service provider operations.

It is the vendored service provider’s responsibility to remain in compliance with the Welfare and Institutions Code by reporting a conflict of interest. It is the regional center employee’s responsibility to eliminate the conflict of interest or obtain a waiver pursuant to the regulations.

Conflict Of Interest Certification

I certify that I am not a current Regional Center or State of California employee.

Service Provider’s
Initials

I certify that I am not the relative (spouse, parent, sibling, or child) of a current Regional Center employee.

<p>I am a relative of a current Regional Center employee. The name of the employee is _____ . His/her telephone number is _____ . The email address is _____ (the Regional Center will contact the individual in accordance with the waiver requirement).</p>	<p>Please read this section carefully</p>
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I certify that I will refrain from providing gifts of any kind to South Central Los Angeles Regional Center (SCLARC) employees that exceed \$25.00 per person annually. I understand that gift giving that exceeds \$25.00 is not in compliance with Title 17 and SCLARC’s Conflict of Interest policy.

I certify that I will immediately report any future conflict or potential conflict of interest to South Central Los Angeles Regional Center.

Name of Applicant or Authorized Representative:

_____ Date: _____

Signature: _____

STATEMENT OF OBLIGATION
(Please attach additional pages if needed)

	YES	No
1. THE APPLICANT IS PRESENTLY PROVIDING SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES:		
2. THE APPLICANT IS PRESENTLY PROVIDING SERVICES TO INDIVIDUALS OTHER THAN THOSE WITH DEVELOPMENTAL DISABILITIES IN RESIDENTIAL SETTINGS OR OTHER RELATED SERVICES. IF YES, INDICATE NAME, LOCATION, TYPE & SERVICE(S)		
3. IS THE APPLICANT CURRENTLY RECEIVING GRANT/FUNDS FROM ANY SOURCE TO DEVELOP SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES? IF YES, INDICATE FUNDING SOURCE AND SCOPE OF GRANT PROJECT.		
4. IS THE APPLICANT CURRENTLY APPLYING FOR GRANT/FUNDS FROM ANY SOURCE TO DEVELOP SERVICES FOR FISCAL YEAR 2019/2020? IF YES, INDICATE FUNDING SOURCE & SCOPE OF GRANT PROJECT.		
5. THE APPLICANT IS PLANNING TO EXPAND EXISTING SERVICES (THROUGH A LETTER OF INTENT AND WITH OR WITHOUT GRANT FUNDS) FROM A SOURCE OTHER THAN SOUTH CENTRAL REGIONAL CENTER DURING FISCAL YEAR 2019/2020: IF YES, PLEASE PROVIDE DETAILS		
6. DESCRIBE OTHER PROFESSIONAL/BUSINESS OBLIGATIONS. INCLUDE NAME, LOCATION, TYPE AND CAPACITY OF SERVICE/OBLIGATION. DO NOT INCLUDE SERVICES YOU EXPECT TO PROVIDE THROUGH THIS GRANT. (PLEASE USE SEPARATE SHEET OF PAPER)		
7. HAS THE APPLICANT OR ANY MEMBER OF THE APPLICANT'S ORGANIZATION RECEIVED A CORRECTIVE ACTION PLAN FROM A REGIONAL CENTER OR CITATION FROM STATE LICENSING AGENCY WITHIN THE LAST 2 YEARS? IF YES, EXPLAIN IN DETAIL.		
8. HAS THE APPLICANT OR MEMBER OF THE APPLICANT'S ORGANIZATION OR STAFF EVER RECEIVED A CITATION FROM ANY AGENCY FOR ABUSE? IF YES, EXPLAIN IN DETAIL.		
9. THE APPLICANT UNDERSTANDS THAT ALL REFERRALS FOR THIS PROJECT WILL BE INDIVIDUALS THAT HAVE BEEN PREVIOUSLY IDENTIFIED BY SCLARC AS READY TO TRANSITION TO THE COMMUNITY FROM IDENTIFIED SETTINGS.		

SAMPLE FINANCIAL STATEMENT

(Reference purposes only - verified financial statement required)

- 1) Verifiable bank statements
 - a. Copies of bank statements must be attached (most current 3 months).

- 2) ONE OF THE FOLLOWING
 - a. Most current audited financial statement that expresses an unqualified opinion; OR
 - b. Compiled financial statements prepared by a Certified Public Accountant that adhere to Generally Accepted Accounting Principles.

- 3) Assets, Liabilities, Income and Lines of Credit (can be in this format):
 - a. Current Assets (to include):
 - Cash in Banks
 - Accounts Receivable
 - Notes Receivable
 - Equipment/Vehicles
 - Inventories
 - Deposits/Prepaid Expenses
 - Life Insurance (Cash Value)
 - Investments Securities (Stocks and Bonds)
 - b. Fixed Assets (to include):
 - Building and/or Structure
 - Real Estate Holdings
 - Long-Term Investments
 - Potential Judgments and Liens
 - c. Current Liabilities:
 - Accounts Payable
 - Notes Payable (Current Portion)
 - Taxes Payable
 - d. Long-Term Liabilities:
 - Notes/Contracts Payable
 - Real Estate Mortgages
 - e. Other Income: Wages or Revenue from other sources (Specify):
 - f. Line of Credit Amount Available: