South Central Los Angeles Regional Center

Request for Proposals
(RFP)

Specialized Adult Residential Facility

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

Request for Proposal	**September 25, 2024**
Bidder Conference	**October 2nd, 2024 at 10:00 a.m. via Zoom**
Proposals Due	**December 2nd, 2024 at 5:00 p.m.**
Interview of the Top Candidates	**February 2025**
Notice of Selection	**May 30th, 2025**

Consistent with the Lanterman Developmental Disabilities Services Act and the promotion of community-based services for all people with Developmental Disabilities, South Central Los Angeles Regional Center (SCLARC) is currently accepting proposals for an Adult's Specialized Residential Facility for Adults ranging in age from 18-59, male or female. The applicant must demonstrate experience and a relevant background in providing services to persons with developmental disabilities.

South Central Los Angeles Regional Center is working collaboratively with the Department of Developmental Services (DDS), and the State Developmental Centers (SDC) to develop alternative community placements for adults with developmental disabilities This specialized residential facility will be licensed as an Adult Residential Facility, pursuant to Community Care Licensing (CCL) requirements Title 22.

Pursuant to the Department of Developmental Services, Specialized Residential Facilities are licensed for individuals who require 24-hour care and supervision for whom an appropriate residential placement is not available.

The facility will be ambulatory and/or non-ambulatory and requires a 24-hour on-site staff. Each adult must have their own room to be in compliance with HCBS Final Rule. Each bedroom will have a full-size bed. The individuals will need support in some or all the following areas: emotional self-regulation, anger management, developing coping skills to minimize self- injurious behavior, forming and maintaining healthy attachments (including safe/appropriate sexual behavior and boundaries), compliance with probation/diversion plans, substance abuse prevention, medication management, health care, and access to mental health services. Individuals may present with a variety of healthcare needs that require restricted healthcare plans to live in the facility. If applicable the applicant must agree to complete restricted health condition care plans for each individual and is obligated to abide by Title 22, Requirements for Restricted Health Conditions, Section 80090-80094.5.

In response to this collaborative effort, South Central Los Angeles Regional (SCLARC) is requesting proposals from interested parties to develop one negotiated rate specialized residential facility. The facility to be developed will be for adult individuals with developmental disabilities ages 18 to 59.

COMMUNITY CARE FACILITIES

Project #SCLARC 2024 – 2025 -10:

Level 4I, Ambulatory and/or non ambulatory, Staff Operated Adult's Residential Facility- Behavior/ Medical Focus.

Age Range: 18 to 59

Gender: 2 Males and 2 Females (All male or all female facility)

Special Needs and Client Characteristics: Behaviors of AWOL, severe physical aggression towards others, property destruction, noncompliance with rules in the home and in the community, sexual misconduct with peers, dual diagnosed with mental health conditions (depression, anxiety and suicidal ideations).

SCLARC will host a bidder's conference to support potential applicants and to address questions via Zoom on October 2nd, 2024 from 10:00am- 11:30pm.

Join Zoom Meeting
https://us06web.zoom.us/j/81010871747?pwd=vF6nQqjD8dDCuwwSezVCbqx5LPWRiz.1

Meeting ID: 810 1087 1747
Passcode: 998167

One tap mobile
+16694449171,,81010871747#,,,,*998167# US
+17193594580,,81010871747#,,,,*998167# US

Dial by your location
• +1 669 444 9171 US
• +1 719 359 4580 US
• +1 720 707 2699 US (Denver)
• +1 253 205 0468 US
• +1 253 215 8782 US (Tacoma)
• +1 346 248 7799 US (Houston)
• +1 646 558 8656 US (New York)
• +1 646 931 3860 US
• +1 689 278 1000 US
• +1 301 715 8592 US (Washington DC)
• +1 305 224 1968 US
• +1 309 205 3325 US
• +1 312 626 6799 US (Chicago)
• +1 360 209 5623 US
• +1 386 347 5053 US
• +1 507 473 4847 US
• +1 564 217 2000 US

Meeting ID: 810 1087 1747
Passcode: 998167

MINIMUM REQUIREMENTS

Applicants must meet the following minimum requirements:

- Applicants/Administrator must meet one or more of Community Care Licensing (CCL) Title 22, Section 85064 requirements:
    - Have a degree in a behavioral science from an accredited college or university, plus a minimum of one year of employment as a social worker, as defined in Section 80001s.(4), in an agency serving adults or in a group residential program for adults.
      Or
    - Have completed at least two years at an accredited college or university, plus at least two years administrative experience or supervisory experience over social work, and/or support staff providing direct services to adult in an agency or in a community care facility.
    - Have completed high school, or equivalent, plus at least three years administrative experience or supervisory experience over social work, and/or support staff providing direct services to adult in an agency or in a community care facility.

- Applicants must be in good standing with Community Care Licensing, State Department of Health Services and any placement agency the applicant may be currently vendored/contracted with.

- Applicants with a history of deficiencies issued by a licensing agency, corrective actions issued by the regional center and/or similar actions taken by a placement or oversight agency may not be considered for this development.

- Applicant must have a sound financial status. Verification of this must be submitted with the proposal.

- Applicants must have a minimum of 2 years' experience working in a level 4 facility providing services to adults with behavioral deficits.

- Applicants applying for any level 4 Health Care/Medical/ Behavior Focus facilities must have a minimum of 2 years' experience working in a level 4 facility providing services to individuals with medical issues.

- The administrator for the group home must have a current adults administrator's certificate from Community Care Licensing, have completed SCLARC's residential services orientation course, and meet the Direct Support Professional Training year one and two training requirement. The individual must also be PART or CPI certified.

- The licensed individual must have a minimum of two years' experience working with persons with developmental disabilities and approved by SCLARC.

GENERAL GUIDELINES

Submission Deadline: ongoing / until the need is fulfilled.

One (1) copy of the proposal must be submitted to SCLARC's Legacy Building receptionist located on the 3rd floor. Or e-mail the proposal to tbdvendors@sclarc.org

Contact: The contact person for the proposals is:

South Central L.A. Regional Center **2500 S. Western Ave.** **Los Angeles, CA 90018**	**Contact: Evelyn Galindo** **evelyng@sclarc.org**

Rejection of Proposals: 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 applicant when it is determined to be in the best interest of SCLARC.

Finalists: SCLARC reserves the right to select any one of the finalists regardless of the proposal score.

Misunderstandings: SCLARC's decision will be final in any manner of interpretation of the RFP (Request for Proposals).

Insurance: If selected to develop the aforementioned program, the applicant must have the appropriate business license, and must take out and maintain liability, worker's compensation and vehicle insurance policies.

Hold Harmless and Indemnification: The applicant will hold harmless and indemnify SCLARC, its officers, agents and employees from and against any and all actions, suits or other proceedings as may arise as a result of the negligence of willful misconduct of SCLARC, its officers, agents and employees.

Timeline

Original Release of Request for Proposal Packets	**September 25, 2024**
Bidder's Conference	**October 2, 2024, at 10:00am via Zoom**
Proposals Due	**December 2nd, 2024**
Interview of candidates	**February 2025**
Notice of Selection	**May 30th, 2025**

PROPOSAL GUIDELINES

GENERAL INSTRUCTIONS
PROPOSAL PACKAGE

A. The following format must be used when completing Proposal. Failure to follow this format will result in an automatic rejection of the Proposal by the SCLARC review committee.

1. Do not use special bindings, covers, notebooks or folders on the proposals.
2. Attach the Proposal using a double-hole punch or staples at the top (middle) of the page.
3. Must use 12-inch font.

B. The Proposal must include all information requested below and provided in **the same order** in your document. Proposals that do not follow this format or fail to include all requested information on this RFP are considered by the committee to be incomplete and will not be considered.

For additional guidance in writing your Service Summary, please refer to Title 17 and Title 22 regulations:

1. Proposal Cover Page (enclosed)
2. Multi-program vendor development questionnaire (enclosed)
3. Resume for the Applicant. The resume must demonstrate compliance with the applicant's minimum requirements and experience working with the identified population.
4. Resume of the Administrator. The resume must demonstrate compliance with the applicant's minimum requirements and experience working with the identified population.
5. For the behavioral facilities, include a resume for the Behavior Consultant providing the direct services and the resume for his/her supervisor (if any) is required. The resume must demonstrate compliance with the applicant's minimum requirements and experience working with the identified population.
6. For the health care/medical focus facilities, include a resume for the Registered Nurse (RN) Consultant. The resume must demonstrate compliance with the applicant minimum requirements and experience working with the identified population.
7. Copies of the current administrator's certificate from Community Care Licensing and Direct Support Professional Training certificates indicating compliance with year one and two requirements. Copies of CPI or PRO-ACT certifications must also be included.
8. Copy of the behavior or RN consultant's license and service agreement/contract.
9. Complete form DS1891 Applicant/Vendor Disclosure Agreement
10. Complete and sign Conflict of Interest Declaration
11. Complete Statement of Obligation
12. Provide Financial Status/Strength/Status
13. Program Design/Program Plan (outline is enclosed).
14. Must have a cover page, Table of Contents and page numbers.

PROPOSAL COVER PAGE

PLACE A COPY OF THIS ATTACHMENT ON THE TOP OF THE PROPOSAL

❑ Proposed Development _____

_____
NAME OF INDIVIDUAL OR ORGANIZATION SUBMITTING PROPOSAL (Please print)

_____
CONTACT PERSON FOR PROJECT / JOB TITLE (Please print)

_____ _____ _____
TELEPHONE NUMBER/ FAX NUMBER/ E-mail address

_____
NAME OF PARENT CORPORATION (IF APPLICABLE) (Please print)

_____
ADDRESS (Please print)

_____
AUTHOR OF PROPOSAL, IF DIFFERENT FROM INDIVIDUAL SUBMITTING PROPOSAL

Knowingly and willfully failing to fully and accurately disclose the information requested may result in rejection of proposal.

A. List up to four current or previous services implemented by the applicant/agency that provide evidence of experience related to your proposal. Include the service name, the dates that services started (and ended if not currently being provided) and a short description of the type/purpose of the indicated service:

1.	
2.	
3.	
4.	

B. List three references that can be contacted in regard to applicant's experience, qualifications and ability to implement this proposal:

1.

Name & Title | Agency Affiliation

Address | Phone

2. Name & Title | Agency Affiliation

Address | Phone

3. Name & Title | Agency Affiliation

Address | Phone

By signing, 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 Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

_____ _____

SIGNATURE OF PERSON AUTHORIZED TO BIND ORGANIZATION DATE

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**

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 questions 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 individuals 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 Client *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): _____**

State of California–Health and Human Services Agency
DS 1891 (7/2011)
Department of Developmental Services

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

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

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

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 Client 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 — Service Provider' s Initials

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

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

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 requirements).	**Please read this section carefully.**

_____

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 OTHERTHAN 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 **2021/2022**? IF **YES,** INDICATE FUNDING SOURCE &SCOPE OF GRANT PROJECT.		
5. THE APPLICANT ISPLANNING TOEXPAND EXISTING SERVICES (THROUGH ALETTER OF INTENT AND WITH OR WITHOUT GRANT FUNDS) FROM A SOURCE OTHER THAN SOUTH CENTRAL REGIONAL CENTER DURING FISCAL YEAR 2021/2022: 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.		

Signature of Applicant or Authorized Representative

Date

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:

SCLARC RESIDENTIAL CARE FACILITY FOR ELDERLY SERVICES PROGRAM DESIGN CONTENT OUTLINE

1. Cover page
2. Table of contents (add page numbers)
3. Statement of purpose.
4. Entrance criteria/Description of consumers served.
5. Description of consumers not appropriate for placement.
6. Exit criteria.
7. Description of basic consumer services provided. Include a statement indicating who plans conducts and assists consumers in participating in the services and activities described in this section.
8. Description of measurable anticipated service outcomes.
9. Description of procedure used to develop consumer individual service plans.
10. Statement of commitment that a vehicle that can accommodate the transportation needs of the consumers will be assigned to the facility. Include statement indicating that direct care staff will be trained to safely escort clients to their outside services and programs and address behavioral issues that may occur in the vehicle.
11. 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.
    a. Teach social skills to assist the individual in learning pro-social behaviors as alternatives to physical aggressive or assaultive behaviors.
    b. 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.
    c. Describe how psychiatric needs of the 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.
12. Data methodology used to measure consumer progress. Include how measurement and reporting of progress on skill training goals will differ from measurement and reporting on the reduction of targeted behavior problems. Include how and for what time periods data will be summarized for reporting.
13. Statement of commitment to preparing and maintaining daily on-going written consumer notes.
14. Statement regarding the preparation and maintenance of quarterly reports of consumer progress. Agreement to submit the report within 30 days of the end of the quarter. The date and signature of the behavior consultant and administrator must be included.

15. Include a sample of a consumer specific treatment plan prepared in conjunction with the designated consultant. This must include: a comprehensive and descriptive information that reflects the skills, deficits or behaviors that the consumer displays; measurable and time limited objectives; antecedents, consequences and function of the behavior; and specific methods to accomplish the identified goals and objectives.
16. Description of the facility's intervention plan. Include techniques initiated to prevent acting out behavior, verbal de-escalation techniques, and the intervention strategies and techniques used in therapeutic physical intervention and any other techniques which will be used to address acting out behavior. State clearly the facility's policy for when and only when CPI or PRO-ACT physical intervention procedures should be used.
17. Sample one month activity schedule. Include information regarding who plans, conducts and assists consumers in participating in outings and other recreational activities. *Security concerns may prevent some clients from participating in activities. Provide structured activities during hours the client would normally be at school.*
18. Consumer rights.
19. House values (rules).
20. Consumer grievance procedure.
21. Consumer theft and loss policy. This must include a commitment to take inventory of the consumer's personal property at the time of admission. There must be a plan for modifying the inventory when the consumer's personal property changes and a description of the practices used to safeguard personal property upon the death of the resident.
22. Special incident reporting procedures.
23. Medication preparation and dispensing procedures:
    a. Include gradual dose reduction plan in place for psychotropic medications.
    b. Include written plan to address of all 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.
24. Statement indicating that medication logs will be maintained.
25. Statement that staff will take "in person" CPR and First Aid Courses.
26. Statement that staff will maintain current CPR and First Aid Certifications.
27. Policy regarding the frequency of nighttime bed checks.
28. Emergency disaster plan.
29. Consumer medical emergency procedures.
30. Consumer hydration policy.
31. Sample menu along with a statement indicating that a menu will be posted.
32. Neighborhood complaint procedure.
33. Sample staff schedule.
34. Actual administrator schedule.
35. Staffing Emergency Procedures.

36. Organizational chart for the facility.
37. Description of the governing body. Specify if facility will be licensed and vendored as an individual/sole proprietor, partnership, limited liability company or corporation. Provide a list of the general partners or corporate offices and the percentage of shares owned by each.
38. Statement that vendor will maintain current liability and worker's compensation insurance and name SCLARC as additional insurance and certificate holder.
39. Demonstrate control of property. If the property is leased, include a copy of the lease agreement or rental agreement. If the property is owned, a copy of the property tax bill, deed or other related document is required.
40. Administrator qualifications and duty statement.
    a. Include statement that Administrator must be on duty for a minimum of 20 hours, part of this time when clients are home.
    b. Identified administrator must have a minimum of 3 years experience working with the target population in a licensed residential setting. This individual must have a current administrators 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.
41. A copy of the administrator's resume confirming that the administrator meets Title 17, Title 22 or the administrator qualifications outlined in the contract.
42. Statement that all staffing will be in place on date that facility becomes operational.
43. Staff qualifications and duty statement.
    a. All Direct Care Staff must; have at least 6 months prior experience providing care to individuals with developmental disabilities. Must have a high school diploma or equivalent.
    b. Include statement that 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 Qualified Behavior Modification Professional.
    c. Include statement that at least one direct care lead staff and one direct care staff must always be on duty at all time, when a client is under supervision of the facility (1:1 24hrs/7days).
    d. Statement that direct care staff must also speak the language of all the clients they support.
44. Consultant qualifications and duty statement.
    a. Include statement that Behaviorist 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. Non 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.

b. Identify mental health and medical clinicians as soon as the location of the property is identified. This includes neurologist, psychiatrist, and general practitioner.
c. Submit written confirmation for each that has admitting privileges at a local hospital.

45. Statement of social worker qualifications (staff operated Adult facilities only).
46. Copy of personnel policies.
    a. Include statement that any direct care staff that has 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.
47. Staff training plan.
    a. Begin First 40 Hours of Providing Services To Consumers
    b. Includes: Program Design; Consumer IPPs; Consumer Rights; Medication Procedures; Health And Emergency Procedures To Include Fire Safety; Identification And Reporting Of Sirs; Identification And Reporting Of Consumer Abuse.
    c. On-The-Job Training As Necessary To Implement Consumer IPPs. d. Zero Tolerance Policy (must be done yearly)
    d. Continuing Education: L4- 12 Hours.
    e. Includes: Consumer Services as Described in the Program Design; Promotion Of Consumer's Rights; Health, Safety, And Social And Physical Integration; ID Team Process, Including The Development And Implementation Of IPPs.
    f. 16 hours of emergency intervention training which must include the techniques that will be used 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 alternative to physical restraints. This training is in addition to CPI, PRO-ACT or PCMA training.
    g. Include statement that staff may not implement emergency interventions prior to successfully completing 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.
48. Statement that all staff providing direct care and supervision to consumers must be PCMA, PRO-ACT or CPI trained before they are allowed to work with clients in the facility.
49. Policy for direct care staff who do not pass the Direct Support Professional Competency-based Training test and for those who pass with knowledge area(s) identified as needing improvement.
50. Statement that unless otherwise indicated in the IPP, vendor will accompany consumers to all medical and dental appointments.
51. Statement that the consumers will not be left without direct staff supervision either in the facility or in the community without written permission from the regional center.

52. Statement that consumers may not participate in school or day programs and the vendor will provide direct care and supervision twenty-four hours per day, seven days per week.
53. Zero Tolerance Policy
54. Whistleblower Policy
55. Drug Policy
56. Statement regarding how the agency will remain culturally competent and staff cultural competency training.
57. Statement that all staff will be fingerprint cleared prior to working with consumers.
58. Staff Recruitment and Retention: Describe your plan to recruit and retain quality staff. Include:
    a. Desired characteristics for all staff positions
    b. Staffing procedures to mitigate staff burnout and provide staff support in stressful work environments.
    c. Health and criminal background screening procedures.
    d. Initial and ongoing training, including required certifications. Include specialized training for providing behavior support and crisis intervention to individuals who have potentially dangerous behaviors.
59. Continuous Quality Improvement (CQI) System: Describe your agency approach to quality assurance to include:
    a. How the service agency will use data, such as agency outcomes, stakeholders 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.).
    b. How processes such as methods and procedures are examined for revision when problem patterns emerge.
    c. Explain the role of consultants in the quality assurance process.
60. HCBS Finale Rule facility descriptions statements and HCBS Finale Rule facility manual.