

**Government of the District of Columbia
Child and Family Services Agency**



HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

MENTAL HEALTH SERVICES – DCRL-2013-H-0030

STATUTORY AND REGULATORY AUTHORITY

The Procurement Practices of the Human Care Agreement Amendment Act of 2000 (D.C. Law 13-155) authorizes the District of Columbia Chief Procurement Officer, or his or her designee, to award Human Care Agreements for the procurement of social, health, human, and education services directly to individuals in the District. The Human Care Agreement Contractor Qualifications Record (CQR) is an application package that will facilitate the process of pre-qualifying contractors for a Human Care Agreement with the District of Columbia in accordance with D.C. Law 13-155 and Chapter 19, 27 DCMR, the regulations.

GENERAL INSTRUCTIONS

1. Please read and complete each section of the Human Care Agreement (HCA), Contractor Qualifications Record (CQR) form. All information must be completed in the spaces provided, or marked "N/A."
2. Original signatures must be included. Copies or a stamped signature is not acceptable.
3. The Standard Contract Provisions (SCP) for use with District of Columbia Government Supplies and Services Contracts dated March 2007 ("SCP") are incorporated as part of the HCA resulting from this CQR. Please read this document carefully before you complete the Contractor's Qualifications Record. To obtain a copy of the SCP go to www.ocp.dc.gov, click on Solicitation Attachment, under "Related Documents", then click on "Standard Contract Provisions (March 2007)". The SCP will be incorporated by reference into each Human Care Agreement that is entered into between a Provider of human care services and the District of Columbia.
4. The following documents shall be completed and returned with package, if requested. To obtain a copy of the documents go to www.ocp.dc.gov click on Solicitation Attachments
 - a. Equal Employment Opportunity (EEO) Information, Mayor's Order 85-85 ()
 - b. Tax Certification Affidavit ()
 - c. First Source Agreement ()
 - d. Cost Price Data Package ()
 - e. Subcontracting Plan ()
5. You may use the "Remarks Section", or attach a separate sheet, to provide additional information.
6. Please include and attach all information, documentation, and data as instructed and required.

In those instances where check boxes are provided, please check only the box or boxes which apply.

CHECKLIST

<input type="checkbox"/>	Did you include your Taxpayer Identification Number?	<input type="checkbox"/>	Did you attach a copy of your most recent Financial Statement?
<input type="checkbox"/>	Did you attach Disclosure Information?	<input type="checkbox"/>	Did you attach a copy of all licenses and certifications, including any specialty certifications?
<input type="checkbox"/>	Did you list all personnel critical to the performance of your Organization?	<input type="checkbox"/>	Did you attach a copy of the Certificate of Occupancy for each facility?
<input type="checkbox"/>	Did you attach a Certificate of Incorporation, if applicable?	<input type="checkbox"/>	Did you attach a Certificate of Good Standing, if applicable?
<input type="checkbox"/>	Did you attach a copy of your LSDBE certification, if applicable?	<input type="checkbox"/>	Did you attach or include your salary history, if applicable?

1. DATE OF FILING / /	2. FILING TYPE: <input type="checkbox"/> NEW <input type="checkbox"/> UPDATE <input type="checkbox"/> CORRECTION <input type="checkbox"/> REMOVAL	(FOR CFSA USE ONLY) DATE RECEIVED BY CFSA:
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SECTION I – GENERAL INFORMATION

1. NAME OF INDIVIDUAL/ ORGANIZATION a. Name: b. Title: c. Physical Street Address: d. City, State & Zip Code: e. Office Phone: f. Office Facsimile No: g. E-Mail:	2. TYPE OF ORGANIZATION <i>(Please check the appropriate box.)</i> <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> CORPORATION <input type="checkbox"/> GENERAL PARTNERSHIP <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> LIMITED PARTNERSHIP 3. STATE OF INCORPORATION <i>(Please check the appropriate box.)</i> <input type="checkbox"/> DISTRICT OF COLUMBIA <input type="checkbox"/> COMMONWEALTH OF VIRGINIA <input type="checkbox"/> STATE OF MARYLAND <input type="checkbox"/> STATE OF DELAWARE <input type="checkbox"/> OTHER: _____ Date Of: _____ 3. TYPE OF ORGANIZATION? <input type="checkbox"/> FOR PROFIT <input type="checkbox"/> NON-PROFIT	
5. SOCIAL SEC. / TAXPAYER ID NO:	6. DUNN & Bradstreet No:	7. ARE YOU OR THE ORGANIZATION CERTIFIED IN D.C. AS? <input type="checkbox"/> Small <input type="checkbox"/> Local <input type="checkbox"/> Disadvantaged <input type="checkbox"/> Resident-Owned <input type="checkbox"/> Enterprise Zone <input type="checkbox"/> Longtime Resident

SECTION II – FINANCIAL RESPONSIBILITY INFORMATION
(Please Provide and Attach a Copy of Your Most Recent Financial Statement)

1. Name and Address of Accountant:	2. Name and Address of Financial Institution:		
3. Name and Title of Contact Person:	4. Name and Title of Contact Person:		
5. Telephone No.:	6. Fax No.:	7. Telephone No.:	8. Fax No.:
9. Date of Attached Financial Statement (Must be Within Last 12 Months):		10. Do You or the Organization Owe Any Outstanding District or Federal Taxes? District Taxes: <input type="checkbox"/> NO <input type="checkbox"/> YES Federal Taxes: <input type="checkbox"/> NO <input type="checkbox"/> YES	

11. MEDICAID – MEDICARE INFORMATION:

a. Are You / Organization a Certified Medicaid Provider? YES NO Medicaid Number: _____ Date: _____

b. Are You / Organization a Certified Medicare Provider? YES NO Medicare Number: _____ Date: _____

SECTION III – DISCLOSURE INFORMATION

(If “yes” to any questions below, please explain fully in REMARKS Section, or attach a separate statement)

1. Have you or the Organization ever been debarred, suspended or sanctioned from any state or federal program?
 YES NO
2. Is your license, or any in the organization, currently suspended or restricted in any way?
 YES NO
3. Have you or the principals of the Organization ever been, indicted, convicted of or pled guilty to a crime (excluding minor traffic citation), or been imprisoned for a crime in the past 10 years?
 YES NO
4. Are there any judgments, or pending civil lawsuits, or investigations against you or the Organization, or its principals?
 YES NO
5. Have you or the Organization ever had any outstanding criminal fines, restitution orders, or overpayments identified in the District or any state?
 YES NO
6. Are you, or is anyone in your organization, related by blood or marriage to any individual employed by the District government?
 YES NO *(if you answered yes, please provide the information below)*

Name: _____ Relationship: _____

SECTION IV – ORGANIZATION HISTORY, BACKGROUND AND EXPERIENCE

1. List All Contracts With the District Government Within the Past Five (5) Years: *(Continue in “Remarks” section or attached sheet)*

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

2. List All Contracts With Other Governments or Private Institutions Within the Past Five (5) Years: *(Continue in “Remarks” section)*

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

3. If You Are Applying As An INDIVIDUAL, Please List Your Employment Or Work History for past five (5) years:

(Continue in “Remarks” Section or attached sheet)

	Name of Employer	Address	Duties	Name of Supervisor	Dates of Employment	Telephone
A					to	
B					to	
C					to	
D					to	
E					to	

SECTION VI – SERVICE DATA AND INFORMATION

1. **GENERAL SERVICE CATEGORIES:** Please Check the General Service Categories for which this Application is Submitted:
 2. CFSA seeks Providers to provide Mental Health Services to children and/or families who are in the care of CFSA.

- Individual Therapy Standard
 - a. Intake Assessment
 - b. Trauma Focused Cognitive/Behavioral Therapy
 - c. Interpersonal/Psychotherapy
 - d. Grief & Loss Counseling
 - e. Anger Management
 - f. Attachment Therapy
 - g. Rational Emotive Behavioral Therapy
- Behavior Modification
 - a. Behavioral assessment
 - b. Applied Behavior Analysis
 - c. One-to-One Behavior Intervention
 - d. Medication Management
 - e. Standard Behavior Modification
- Family Services
 - a. intake Assessment
 - b. Family Counseling
 - c. Couples Counseling
 - d. Family Attachment
 - e. Sibling w/o Parent
 - f. Anger Management
- Intensive In-Home Family Preservation/Reunification
 - a. Intake Assessment
 - b. Intensive In Home Family Preservation/Reunification
- Specialty Services
 - a. Initial Assessment
 - b. Sex Abuse/Sex Offender Treatment (victim/perpetrator)
 - c. Sex Abuse Therapy
 - d. Dialectical Behavior Therapy
 - e. Art Therapy
 - f. Play Therapy

- Evaluation standard
 - a. Psycho-Sexual Evaluation
 - b. Psychological Evaluation
 - c. Psycho-Educational Evaluation
 - d. Psychiatric Evaluation
 - e. Neuro-Psychological
- Individual Therapy Standard
 - a. Trauma Focused Cognitive/Behavioral Therapy
 - b. Interpersonal/Psychotherapy
 - c. Grief & Loss Counseling
 - d. Anger Management
 - e. Attachment Therapy
 - f. Rational Emotive Behavioral Therapy
- Behavior Modification
 - a. Behavioral Assessment
 - b. Applied Behavior Analysis
 - c. One-to-One Behavior Intervention
 - d. Medication Management
 - e. Standard Behavior Modification
- Family Services
 - a. Intake Assessment
 - b. Family Counseling
 - c. Couples Counseling
 - d. Family Attachment
 - e. Sibling w/o Parents
 - f. Anger Management
- Intensive In-Home Family Preservation/Reunification Assessment
 - a. Intake Assessment
 - b. Intensive In Home Family Preservation/Reunification

2. LANGUAGE SKILLS: Please Check All that Apply in terms of Language Skills:

- | | | |
|---|---|--|
| <input type="checkbox"/> English (ENG) | <input type="checkbox"/> French (FRN) | <input type="checkbox"/> Chinese–Cantonese (CCA) |
| <input type="checkbox"/> Spanish (SPN) | <input type="checkbox"/> Haitian Creole (CRE) | <input type="checkbox"/> Chinese-Mandarin (CMA) |
| <input type="checkbox"/> International/Universal Sign (SGN) | <input type="checkbox"/> Vietnamese (VTN) | <input type="checkbox"/> Ethiopian (Amharic) (AMH) |
| <input type="checkbox"/> Italian (ITL) | <input type="checkbox"/> Korean (KOR) | <input type="checkbox"/> Others: _____ |

SECTION VI – SERVICE DATA AND INFORMATION

- 1. GENERAL SERVICE CATEGORIES: Please Check the General Service Categories for which this Application is Submitted:**
 2. CFSA seeks Providers to provide Mental Health Services to children and/or families who are in the care of CFSA.

<p><input type="checkbox"/> Specialty Services</p> <ul style="list-style-type: none"> a. Initial assessment b. Sex Abuse/sex Offender c. Sex Abuse Therapy d. Dialectical Behavior Therapy e. Art Therapy f. Play Therapy <p><input type="checkbox"/> Evaluation Standard</p> <ul style="list-style-type: none"> a. Psycho-Sexual Evaluation b. Psychological Evaluation c. Psycho-Educational Evaluation d. Psychiatric Evaluation e. Neuro-Psychological Evaluation <p><input type="checkbox"/> Individual therapy Standard</p> <ul style="list-style-type: none"> a. Trauma Focused Cognitive/Behavioral Therapy b. Interpersonal Psychotherapy c. Grief & Loss Counseling d. Anger Management e. Attachment Therapy f. Rational Emotive Behavioral Therapy 	<p><input type="checkbox"/> Behavioral Modification</p> <ul style="list-style-type: none"> a. Behavioral Assessment b. Applied Behavior Analysis c. One-to-One Behavior Intervention d. Medication Management e. Standard Behavior Modification <p><input type="checkbox"/> Family Services</p> <ul style="list-style-type: none"> a. Intake assessment b. Family Counseling c. Couples Counseling d. Family Attachment e. Sibling w/o Parents f. Anger Management <p><input type="checkbox"/> Intensive In-Home Family Preservation/Reunification</p> <ul style="list-style-type: none"> a. Intake Assessment b. Intensive In Home Family Preservation/Reunification
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2. LANGUAGE SKILLS: Please Check All that Apply in terms of Language Skills:

<input type="checkbox"/> English (ENG)	<input type="checkbox"/> French (FRN)	<input type="checkbox"/> Chinese–Cantonese (CCA)
<input type="checkbox"/> Spanish (SPN)	<input type="checkbox"/> Haitian Creole (CRE)	<input type="checkbox"/> Chinese-Mandarin (CMA)
<input type="checkbox"/> International/Universal Sign (SGN)	<input type="checkbox"/> Vietnamese (VTN)	<input type="checkbox"/> Ethiopian (Amharic) (AMH)
<input type="checkbox"/> Italian (ITL)	<input type="checkbox"/> Korean (KOR)	<input type="checkbox"/> Others: _____

SECTION VII – REMARKS SECTION

Please use this section for additional response to any previous request for information. In addition, please feel free to use this section to provide additional information pertinent to determining qualifications for entering into a Human Care Service Agreement with the District of Columbia's Child and Family Services Agency.

SECTION VIII – CERTIFICATIONS AND INCORPORATIONS BY REFERENCE

1. DRUG-FREE WORKPLACE CERTIFICATION: *Please provide certification that you or the Organization will operate in a Drug-Free Manner.*

I/We, _____ of _____

Hereby give, affirm and provide certification that I/We have received and have read the requirements on having and maintaining a Drug-Free Workplace in the District of Columbia, agree to be bound by those requirements and the remedies stated in the requirements, and further certify that I/We realize that making a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

Name (Please Print)	Title	Signature	Date
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(May be signed on behalf of individual or organization.)

2. STANDARD CONTRACT PROVISIONS FOR USE WITH DISTRICT OF COLUMBIA SUPPLY AND SERVICES CONTRACTS: *Please provide Certification that You or the Organization Agrees to be bound by the Standard Contract Provisions of the District of Columbia.*

I/We, _____ of _____

Hereby give, affirm and provide certification that I/we have received and have read the Standard Contract Provisions For Use With District of Columbia Government and Supply Contracts (“Standard Contract Provisions”), dated March 2007, and agree to be bound by all of the provisions, including The requirements of the Occupational Safety and Health Act of 1970 (as amended), the Service Contract Act of 1965 (41 U.S.C. 351-358), the Buy America Act (41 U.S.C.), and the Non-Discrimination provisions. Further, I/We agree and understand that the Standard Contract Provisions shall be Incorporated by reference into any contract or agreement that shall be signed between Me, or My Organization, and the District of Columbia.

Name (Please Print)	Title	Signature	Date
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3. INFORMATION CONSENT: *Please Provide Certification that you or the organization Provide Consent To The District To Obtain Additional Information As Needed.*

I/We, _____ of _____

Hereby give, provide and express my consent for representatives of the Child and Family Services Agency, Government of the District of Columbia, to obtain any information from any professional organization, business entity, individual, government agency, or academic institution concerning the Professional license status or certification referenced in this document. This material shall be held, maintained and updated by the Child and Family Services Agency. I further understand that the Child and Family Services Agency will use this information solely for internal purposes pertaining to the evaluation of the qualifications of individuals and organizations to provide human care services, as appropriate, in the District of Columbia.

Name (Please Print)	Title	Signature	Date
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