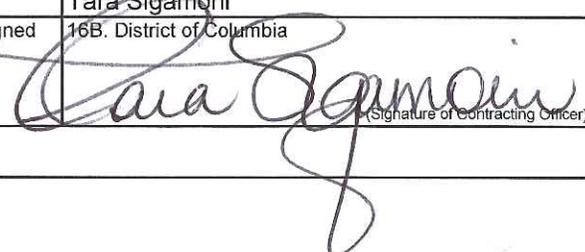


<b>AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT</b>			1. Contract Number	Page of Pages 1   33
2. Amendment/Modification Number M0002	3. Effective Date See 16C	4. Requisition/Purchase Request No.	5. Solicitation Caption: Mental Health Services	
6. Issued By: District of Columbia Child and Family Services Agency Contracts and Procurement Administration 200 I Street, SE Suite 2031 Washington, DC 20003		Code	7. Administered By (If other than line 6)	
8. Name and Address of Contractor (No. Street, city, country, state and ZIP Code)		x	9A. Amendment of Solicitation No. DCRL-2013-R-0083	
			9B. Dated (See Item 11) 5/3/2013	
			10A. Modification of Contract/Order No.	
			10B. Dated (See Item 13)	
Code	Facility			
<b>11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS</b>				
<input checked="" type="checkbox"/>	The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offers <input checked="" type="checkbox"/> is extended, <input type="checkbox"/> is not extended. Offers must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation or as amended, by one of the following methods: (a) By completing Items 8 and 15, and returning <u>1</u> copies of the amendment; (b) By acknowledging receipt of this amendment on each copy of the offer submitted; or (c) By separate letter or fax which includes a reference to the solicitation and amendment number. FAILURE OF YOUR ACKNOWLEDGEMENT TO BE RECEIVED AT THE PLACE DESIGNATED FOR THE RECEIPT OF OFFERS PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If by virtue of this amendment you desire to change an offer already submitted, such change may be made by letter or fax, provided each letter or telegram makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.			
12. Accounting and Appropriation Data (If Required)				
<b>13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS, IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14</b>				
	A. This change order is issued pursuant to: (Specify Authority) The changes set forth in Item 14 are made in the contract/order no. in item 10A.			
	B. The above numbered contract/order is modified to reflect the administrative changes (such as changes in paying office, appropriation date, etc.) set forth in item 14, pursuant to the authority of 27 DCMR, Chapter 36, Section 3601.2.			
	C. This supplemental agreement is entered into pursuant to authority of:			
	D. Other (Specify type of modification and authority) 27 DCMR, Chapter 20 Section 2008 Exercise of Options			
<b>E. IMPORTANT:</b> Contractor <input type="checkbox"/> is not, <input checked="" type="checkbox"/> is required to sign this document and return <u>1</u> copies to the issuing office.				
14. Description of amendment/modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible.) <b>Pursuant to 27 DCMR, Section 3601.2 and Paragraph 15 of the Standard Contract Provision for use with District of Columbia Supply and Services contract, dated March 2007, the following changes are incorporated and hereby made part of the contract:</b>				
1. The proposal closing date is hereby extended from May 31, 2013 to June 21, 2013.				
2. Delete page 75 of the solicitation and replace with page 75R.				
3. The log in sheet, dated May 24, 2013, for Pre-Proposal Conference is attached.				
4. Delete Human Care Agreement on the the attached "Log in Sheet" and insert Request for Proposal (RFP).				
Except as provided herein, all terms and conditions of the document referenced in Item (9A or 10A) remain unchanged and in full force and effect				
15A. Name and Title of Signer (Type or print)		16A. Name of Contracting Officer Tara Sigamoni		
15B. Name of Contractor	15C. Date Signed	16B. District of Columbia	16C. Date Signed	
(Signature of person authorized to sign)		(Signature of Contracting Officer)	5/30/13	

**SECTION J: ATTACHMENTS**

The following list of attachments is incorporated into the solicitation by reference.

<b>Attachment Number</b>	<b>Document</b>
<b>J.1</b>	Government of the District of Columbia Standard Contract Provisions for Use with the Supplies and Services Contracts (March 2007) available at <a href="http://www.ocp.dc.gov">www.ocp.dc.gov</a> click on "Solicitation Attachments"
<b>J.2</b>	U.S. Department of Labor Wage Determination No.: 2005-2103, Revision No. 12, dated June 13, 2012
<b>J.3</b>	Office of Local Business Development Equal Employment Opportunity Information Report and Mayor's Order 85-85 available at <a href="http://www.ocp.dc.gov">www.ocp.dc.gov</a> click on "Solicitation Attachments"
<b>J.4</b>	Department of Employment Services First Source Employment Agreement available at <a href="http://www.ocp.dc.gov">www.ocp.dc.gov</a> click on "Solicitation Attachments"
<b>J.5</b>	Way to Work Amendment Act of 2006 - Living Wage Notice
<b>J.6</b>	Way to Work Amendment Act of 2006 - Living Wage Fact Sheet
<b>J.7</b>	Tax Certification Affidavit
<b>J.8</b>	Identity and Procedure Verification
<b>J.9</b>	Mental Health Services Budget Package
<b>J.10</b>	Subcontracting Plan



**CHILD AND FAMILY SERVICES AGENCY  
 MENTAL HEALTH SERVICES  
 SCHEDULE 2  
 FRINGE BENEFIT COSTS**

**PROVIDER NAME: 0** \_\_\_\_\_

**SERVICE TYPE: 0** \_\_\_\_\_

**RFP/CONTRACT NUMBER: 0** \_\_\_\_\_

**CONTRACT PERIOD-FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

A	B
<b>FRINGE BENEFIT TYPES</b>	<b>FRINGE BENEFIT COSTS</b>
FICA	
HEALTH INSURANCE	
LIFE INSURANCE	
ACCIDENT/DISABILITY INSURANCE	
LONG TERM DISABILITY	
WORKERS COMPENSATION	
PENSION/RETIREMENT	
UNEMPLOYMENT COMPENSATION	
401K BENEFITS	
OTHER BENEFITS (Specify below):	
<b>TOTALS</b>	<b>\$ -</b>

**PERCENTAGE OF FRINGE BENEFITS TO TOTAL SALARIES/WAGES:**



**CHILD AND FAMILY SERVICES AGENCY  
MENTAL HEALTH SERVICES  
SCHEDULE 4  
OCCUPANCY COSTS**

**PROVIDER NAME: 0** \_\_\_\_\_

**SERVICE TYPE: 0** \_\_\_\_\_

**RFP/CONTRACT NUMBER: 0** \_\_\_\_\_

**CONTRACT PERIOD-FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

A	B	C	D	E
EXPENSE ITEMS	FACILITY #1 COSTS	FACILITY #2 COSTS	FACILITY #3 COSTS	TOTAL OCCUPANCY COSTS
Rent-Office Space				\$ -
Depreciation-Office Space				\$ -
Gas/Electric/Oil/Water				\$ -
Trash				\$ -
Building Maintenance				\$ -
Property Insurance				\$ -
Pest Control				\$ -
Building Repairs				\$ -
Security				\$ -
Other (specify below):				
				\$ -
				\$ -
				\$ -
<b>SUBTOTALS</b>	\$ -	\$ -	\$ -	\$ -

**NAME/ADDRESS OF \*FACILITIES TO BE USED IN DELIVERING THE PROPOSED SERVICES:**

**FACILITY #1:** \_\_\_\_\_

**FACILITY #2:** \_\_\_\_\_

**FACILITY #3:** \_\_\_\_\_

**\*Facilities must correspond to those designated in Schedules 4 through 11.**

**CHILD AND FAMILY SERVICES AGENCY  
 MENTAL HEALTH SERVICES  
 SCHEDULE 5  
 TRAVEL/TRANSPORTATION COSTS**

**PROVIDER NAME: 0** \_\_\_\_\_

**SERVICE TYPE: 0** \_\_\_\_\_

**RFP/CONTRACT NUMBER: 0** \_\_\_\_\_

**CONTRACT PERIOD-FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

A	B
<b>EXPENSE ITEMS</b>	<b>TOTAL TRAVEL COSTS</b>
<b>VEHICLE LEASE/RENT</b>	
<b>VEHICLE DEPRECIATION</b>	
<b>GASOLINE/OIL/SUPPLIES</b>	
<b>MAINTENANCE/REPAIRS</b>	
<b>AUTO INSURANCE</b>	
<b>AUTO REGISTRATION</b>	
<b>PARKING</b>	
<b>MILEAGE REIMBURSEMENT</b>	
<b>TOTAL</b>	<b>\$ -</b>

CHILD AND FAMILY SERVICES AGENCY  
 MENTAL HEALTH SERVICES  
 SCHEDULE 6  
 SUPPLIES AND MINOR EQUIPMENT COSTS

PROVIDER NAME: 0 \_\_\_\_\_

SERVICE TYPE: 0 \_\_\_\_\_

RFP/CONTRACT NUMBER: 0 \_\_\_\_\_

CONTRACT PERIOD-FROM: \_\_\_\_\_ TO: \_\_\_\_\_

A	B	C	D	E
EXPENSE ITEMS	FACILITY #1 COSTS	FACILITY #2 COSTS	FACILITY #3 COSTS	TOTAL SUPPLIES/ MINOR EQUIPMENT
OFFICE SUPPLIES				\$ -
OFFICE FURNITURE				\$ -
OFFICE EQUIPMENT				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
<b>TOTALS</b>	\$ -	\$ -	\$ -	\$ -

CHILD AND FAMILY SERVICES AGENCY  
 MENTAL HEALTH SERVICES  
 SCHEDULE 7  
 CAPITAL EQUIPMENT AND OUTLAYS COSTS

PROVIDER NAME: 0 \_\_\_\_\_

SERVICE TYPE: 0 \_\_\_\_\_

RFP/CONTRACT NUMBER: 0 \_\_\_\_\_

CONTRACT PERIOD-FROM: \_\_\_\_\_ TO: \_\_\_\_\_

A	B	C	D	E
EXPENSE ITEMS	FACILITY #1 COSTS	FACILITY #2 COSTS	FACILITY #3 COSTS	TOTAL CAPITAL OUTLAYS
VEHICLE PURCHASE				\$ -
MAJOR REPAIRS				\$ -
MAJOR EQUIPMENT				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
<b>TOTALS</b>	\$ -	\$ -	\$ -	\$ -



**CHILD AND FAMILY SERVICES AGENCY  
 MENTAL HEALTH SERVICES  
 SCHEDULE 10  
 OTHER DIRECT COSTS**

**PROVIDER NAME: 0** \_\_\_\_\_

**SERVICE TYPE: 0** \_\_\_\_\_

**RFP/CONTRACT NUMBER: 0** \_\_\_\_\_

**CONTRACT PERIOD-FROM: 1/0/1900 TO: 1/0/1900**

A	B	C	D	E
EXPENSE ITEMS	FACILITY #1 COSTS	FACILITY #2 COSTS	FACILITY #3 COSTS	TOTAL OTHER DIRECT
.....				\$ -
.....				\$ -
.....				\$ -
.....				\$ -
.....				\$ -
.....				\$ -
.....				\$ -
<b>TOTALS</b>	\$ -	\$ -	\$ -	\$ -

**CHILD AND FAMILY SERVICES AGENCY  
 MENTAL HEALTH SERVICES  
 SCHEDULE 11  
 INDIRECT/OVERHEAD COSTS**

**PROVIDER NAME: 0** \_\_\_\_\_

**SERVICE TYPE: 0** \_\_\_\_\_

**RFP/CONTRACT NUMBER: 0** \_\_\_\_\_

**CONTRACT PERIOD-FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

A	B	C	D	E
EXPENSE ITEMS	FACILITY #1 COSTS	FACILITY #2 COSTS	FACILITY #3 COSTS	TOTAL INDIRECT/OVERHEAD
AUDIT				\$ -
ADMINISTRATION				\$ -
FINANCIAL MANAGEMENT				\$ -
OTHER OVERHEAD COSTS (please itemized below):				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
<b>TOTALS</b>	\$ -	\$ -	\$ -	\$ -

**DISTRICT OF COLUMBIA  
CHILD AND FAMILY SERVICES AGENCY  
MENTAL HEALTH SERVICES  
BUDGET PACKAGE (CERTIFIED COST AND PRICING DATA)**

**BUDGET PACKAGE COVER SHEET**

**PROVIDER:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**CONTACT NAME:** \_\_\_\_\_

**SERVICE:** \_\_\_\_\_

**ORIGINAL**

**REVISION**

**CONTRACT NO:** \_\_\_\_\_

**CONTRACT ADMENDMENT/REVISION (NUMBER \_\_\_\_\_)**

**PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_**

**DATE DELIVERED/MAILED TO CFSA: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_**

**CERTIFIED BY AUTHORIZED PROVIDER OFFICIAL:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

**NOTE: ALL INFORMATION MUST BE SUBMITTED TO THE CONTRACTS AND PROCUREMENT ADMINISTRATION, c/o Contracts and Procurement Administrator, 200 I Street SE, Suite 2031, Washington, DC 20003. Any information submitted to any other location or person shall not be considered.**

**RECEIVED IN CFSA/CONTRACTS AND PROCUREMENT ADMINISTRATION:**

**DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**RECEIVED BY:** \_\_\_\_\_  
Name and Title

**BUDGET PACKAGE COMPLETE  
(ALL SCHEDULES COMPLETED, INCLUDING ALL REQUIRED ATTACHMENTS AND BUDGET NARRATIVE)**

**ADEQUATE NUMBER OF COPIES SUBMITTED (ONE (1) ORIGINAL AND THREE (3) COPIES)**

**DISTRICT OF COLUMBIA  
CHILD AND FAMILY SERVICES AGENCY  
MENTAL HEALTH SERVICES  
BUDGET PACKAGE INSTRUCTIONS**

The following schedules comprise the Child and Family Services Agency (CFSA) budget package:

Budget Package Cover Sheet

Schedule 1: Salary and Wage Justification

Schedule 2: Fringe Benefit Justification

Schedule 3: Consultants/Experts Justification

Schedule 4: Occupancy Cost Justification

Schedule 5: Travel and Transportation Cost Justification

Schedule 6: Supplies and Minor Equipment Cost Justification

Schedule 7: Capital Equipment and Outlays Cost Justification

Schedule 8: Client Expense Cost Justification

Schedule 9: Communications Cost Justification

Schedule 10: Other Direct Cost Justification

Schedule 11: Indirect/Overhead Cost Justification

Budget Summary

Hourly Rate Calculation Worksheet

The budget package serves as part of the certified cost and pricing data required by the Government of the District of Columbia, Child and Family Services Agency (District, CFSA or the Agency). The provider is required to complete all sections of the budget package according to these instructions and any other instructions provided by the District. All schedules must be completed and the appropriate documentation attached, as stated in these instructions. Failure to provide required documentation shall result in the rejection of the provider's Offer. Provide/attach additional sheets as necessary.

This budget package should be completed after the offering organization has developed a complete and detailed budget for operating the service(s) being proposed. The organization's own budgeting process may not be substituted for these CFSA forms/templates or instructions.

## GENERAL INSTRUCTIONS

- The forms/worksheets in the CFSA Budget Package should be completed in the following order:
  - 1) Budget Package Cover Sheet
  - 2) Schedules 1 thru 11
  - 3) Budget Summary
  - 4) Hourly Rate Calculation Worksheet
- Ensure the “TOTALS” from Columns (1) thru (11) of each Schedule (1 thru 11) populates or are posted to the Budget Summary. The Budget Summary should populate upon the accurate completion of Schedule 1 thru 11. Should the Budget Summary not populate correctly, please post the totals from each Schedule to the appropriate column/cell on the Budget Summary.
- In completing the budget, vendors are to distinguish the costs associated with each facility that the vendor proposes to use to provide services. The budget schedules give space for three (3) facilities. For each Schedule, determine the number of facilities to be utilized, and if necessary, either delete the extra “facility” columns/cells or insert additional ones.
- In general, “minor” is defined as an item costing \$5,000 or less; “major” is defined as an item costing more than \$5,000.
- Each worksheet has been pre-formatted (Microsoft Office-Excel 2007) to show whole dollars. Should the pre-set format fail, either re-format the appropriate cells to show whole dollars; or use whole dollar amounts, rounding amounts of 50 cents or more up to the next whole dollar and amounts of 49 cents or less down to the next whole dollar.
- All proposed items of cost must be supported by documented/audited historical expenditure data. Providers should be prepared to provide financial documentation in the form of journals, ledgers, registers, billing statements, bank statements, lease/rental agreements, mortgage documents and/or receipts to support any/all proposed costs.
- Provider must also submit a Budget Narrative which provides detailed justification for each proposed item of cost not already included in an attachment to a particular budget schedule. The Budget Narrative is an essential part of the provider's budget submission.
- The specific instructions the each form and schedule are on the following pages. Please read all instructions carefully. Failure to include all information required by each schedule, including all attachments, shall result in the rejection of the Offer.

## BUDGET PACKAGE COVER SHEET INSTRUCTIONS

The Budget Package Cover Sheet should be completed as follows:

**Provider:** enter the name of the organization offering to provide the service. If different levels of a single organization are involved (e.g., a separately named entity within the larger organization), enter the name of the organization with ultimate financial responsibility for delivering the service.

**Original/Revision:** enter an "X" in the appropriate box to show whether this package is the original budget (the one first submitted to CFSA for the period covered) or a revision. If a revision, enter the sequential number of the revision (e.g. the first revision is Number 1, etc.).

**RFP/Contract No:** enter the Request for Proposal number corresponding to the RFP under which the vendor is proposing to provide service. Enter the Contract number if this budget is for a renewal, amendment or extension to a contract in force. **In the event CFSA has not provided a contract number or RFP number, please leave this field blank.**

**Contract Period-From (To):** enter the beginning and end dates to be covered by the proposed budget.

**Approved By Authorized Provider Official:** print/enter the name of the person officially authorized to represent the Provider entity in these negotiations.

**Authorizing Official's Title:** print/enter the title of the authorizing official.

**Authorizing Official's Signature/Date:** the authorized official must sign and date.

**Date Delivered/Mailed to CSFA:** print/enter the date the complete Budget Package was delivered or mailed to CFSA.

The accurate completion of the Cover Sheet should populate the corresponding data to be entered on the "Unit Cost/Daily Per Diem Rate Worksheet"; the "Budget Summary"; and Schedules 1 thru 11.

## SCHEDULE 1: SALARY AND WAGE JUSTIFICATION

This Schedule details the salaries/wages to be paid to each of the organization's employees for the provision of services under this contract.

**A - Employee Name:** Enter the name of the person who will fill each position. If an individual has not yet been hired, enter "TBF" for "To be Filled," and enter the date on which the position is to be filled. **Attach** the job announcement and a commitment letter stating offeror's intent to hire contingent upon award of this contract.

**B - Position Title:** Enter the title of each position to be funded for the provision of services under this contract.

**C - Salary/Hourly:** Indicate with an "X" in the appropriate column/cell, whether the position is salaried or hourly/wage based.

**D - Annual Salary/Wage:**

*For salaried positions:* enter the full base salary corresponding to the period covered by this budget. (Note: include in base salary the amounts paid for vacation, holidays, and other leave. Bonuses, personal use of organizational assets, auto allowances, and other cash-value fringe benefits should be included in salary). Include any anticipated salary increase for each position by pro-rating the increase salary over the period after the increase is anticipated to be given.

If a position is "To Be Filled (TBF)," enter the salary corresponding to the part of the period the position will be paid.

*For hourly positions:* for full-time or part-time hourly employees enter their hourly rate of pay.

**E - Percentage (%) of Time/Salary or Number (#) of Hours/Wage:** The entry in this column will differ, depending on whether the position is on salaried or hourly wage based.

*For salaried positions:* enter the percentage of overall time the individual will dedicate to this contract (Note: the entry cannot exceed 100 percent).

*For hourly positions:* enter the maximum number of hours the individual will dedicate to this contract (Note: the entry cannot exceed 2080 hours, which equates to a full time equivalent).

Enter the amount calculated by multiplying the figures in column D (Annual Salary/Hourly Wage) times column E (Percentage (%) of Time/Salary or Number (#) of Hours/Wage) in the appropriate column representing the proposed service type program:

**F - Total Salary/Wage Costs:** This is the total cost for personnel. Multiply column D times column E, and post the amount in this column.

## SCHEDULE 2: FRINGE BENEFIT JUSTIFICATION

This Schedule details the amount that will be paid by the organization on behalf of employees carrying out the work of this contract for each of the following categories of fringe benefits.

### Column A –Benefits Types

**FICA**: the amount paid by the employer (separate from the amount withheld from an employee's salary or wages). Contributions are made at a rate fixed by Federal law. Currently, the rate is 7.65 percent. When rate is expected to change for another calendar year, make separate calculations for the part of each period to be covered by this contract.

**Health/Hospitalization Insurance**: the amount paid by the employer for health, hospitalization, dental, accidental, disability, or life insurance (in addition to any amount withheld from an employee's salary or wages). A **CERTIFICATE OF INSURANCE** is required to document hospitalization, life insurance and/or long-term disability.

**Worker's Compensation**: the amount paid by the employer for mandatory worker's compensation insurance under Federal and District or State law. The rate of employer contribution is experience-rated. Attach a **CERTIFICATE OF INSURANCE** showing the schedule of benefits for worker's compensation.

**Unemployment Insurance**: the amount paid by the employer for mandatory unemployment insurance under Federal and District or State law. The rate of employer contribution is experience-rated. Attach **THE CONTRIBUTION RATE NOTICE** for unemployment insurance.

**Other Benefits (any other employer-paid benefits)**: Attach justification for any additional fringe benefits offered to employees. (Bonuses, personal use of organizational assets, auto allowances, and other cash value fringe benefits should be included in salary. Do not include vacation or other leave in this category – leave is included in salary).

### Columns B-Fringe Benefits Costs

Enter the total amount of fringe benefits payable.

Note: It is currently the policy of CFSA to cap reimbursement of the proposed fringe benefit rate costs under its contract at a **maximum of 30.0 percent**. Any proposed fringe benefit rate costs in excess of the 30% maximum should not be allocated to a CFSA program.

### SCHEDULE 3: CONSULTANTS/EXPERTS JUSTIFICATION

This schedule details the proposed expenditures by the organization to consultants, specialists, experts and other contract employees who will be paid no fringe benefits. It is completed by filling out the following five columns.

**Column A – Company/Consultant’s Name:** enter the name of the person who will fill each position. **Attach** a copy of the signed consultant agreement. If an individual has not yet been hired, enter “TBF” for “To be Filled,” and enter the date on which the position is to be filled. **Attach** a job announcement and a commitment letter stating offeror’s intent to hire contingent upon award of contract.

**Column B - Position Title:** enters the title of each position to be filled by a consultant or expert (e.g. Consulting Pediatrician, Social Worker, etc.).

**Column C - Base Rate/Hour:** enter the basic rate at which the consultant or expert will be paid for each hour worked. If the payment basis is other than hourly (e.g. daily or monthly), convert to an hourly rate and attach justification for other than hourly payment.

**Column D - No. of Hours for Period:** enter the number of hours each consultant or expert will work during the period specified for delivering this service.

**Column E - Total Consultant Costs:** multiply the entry in column C by the entry in column D to determine the total amount of compensation for consultants and experts covered by this budget.

## SCHEDULE 4: OCCUPANCY COST JUSTIFICATION

This schedule details the proposed expenditures by the organization for occupying space necessary to carry out the planned service.

The schedule is completed by filling out four columns with summary information on the amounts budgeted for the following categories of occupancy cost:

**Rent-Office Space:** rental or lease payment for office space used to support the delivering of service. Attach a complete copy of the lease or rental agreement. Attach justification of lease costs in excess of \$8.00 per square foot. (Note: If space is owned, enter mortgage or depreciation amounts and attach documentation).

**Gas/Electric/Oil/Water:** utilities necessary to carry out the service. Attach separate documentation for each component of utility cost.

**Trash:** separately contracted trash and solid-waste removal. If no special contract arrangements are necessary (i.e. municipal removal) enter "N/A."

**Maintenance:** separately contracted janitorial and maintenance services. If no special arrangements are necessary (i.e. provided by employees), enter "N/A."

**Insurance:** separately paid fire, liability or accident insurance associated with specific space. If no special arrangements are necessary (i.e., provided under a master policy for all sites), enter "N/A."

**Pest Control:** separately contracted pest control and/or extermination services. If no special arrangements are necessary (i.e., provided by employees) enter "N/A."

**Building Repairs:** separate repair costs.

**Security:** the cost of non-employee security.

**Other:** all other costs related to occupying space for the purpose of delivering the identified service. Attach explanation and documentation.

## **SCHEDULE 5: TRAVEL AND TRANSPORTATION JUSTIFICATION**

This Schedule records the proposed expenditures by the organization for travel and transportation necessary to carry out the planned service.

The Schedule is completed by filling out three columns with summary information on the amounts budgeted for the following categories of travel and transportation cost:

**Vehicle Lease:** rental or lease payments for autos, vans, or trucks used in delivering the service. Attach a description of the vehicle and copy of the lease.

**Vehicle Depreciation:** “accounting-type” charges to account for the future replacement cost of a vehicle already owned. (Note: Vehicles purchased with city, state or federal government funds may be depreciated).

**Gasoline/Oil/Supplies:** “consumable” supplies necessary to operate vehicles in order to provide travel and transportation in support of the service. Attach separate documentation of each element of cost for each vehicle.

**Tires/Batteries:** “major” items of expense relative to operating vehicles for travel and transportation to support the planned service. (In general, maintenance and repairs for vehicles not owned or leased by the organization are not allowable).

**Maintenance and Repairs:** routine maintenance and required repairs of vehicles used in providing travel and transportation to support the planned service. (In general, maintenance and repairs for vehicles not owned or leased by the organization are not allowable).

**Insurance:** collision, liability and other insurance related to providing travel and transportation to support the planned service.

**Registration:** vehicle registration and licensing related to providing travel and transportation to support the planned service.

**Mileage/Fares:** mileage reimbursements and taxi/subway/bus fares related to providing travel and transportation to support the planned service.

**Other:** all other costs related to providing travel and transportation to support the planned service. Attach explanation and documentation.

## SCHEDULE 6: SUPPLIES AND MINOR EQUIPMENT COST JUSTIFICATION

This schedule details the proposed expenditures by the organization for various supplies and minor equipment necessary to carry out the planned service.

Using one column for each proposed facility, record the amounts budgeted for the following categories of supplies/equipment cost and attach explanation and documentation:

**Office Supplies:** paper, pencils and other consumable supplies used in delivering the service. (Note: If most office supplies are used in a central/administrative office, identify one of the "Facility" columns as this office and enter all budgeted amounts under that column).

**Office Furnishings:** small/minor office furniture and/or equipment used to support the deliver of the proposed service.

**Other Supplies:** all other supplies required for the purpose of delivering the identified service. These supplies must be itemized in this Schedule.

**Other Equipment:** all other equipment costs for the purpose of delivering the identified service. This equipment must be itemized in this Schedule.

## **SCHEDULE 7: CAPITAL EQUIPMENT AND OUTLAYS COST JUSTIFICATION**

This Schedule details the amounts to be paid by the organization for capital equipment and other major outlays to carry out the planned service.

Using one column for each proposed facility, record the amounts budgeted for the following categories of capital equipment cost:

**Vehicle Purchase:** vehicles purchased for use in delivering the service. This includes cars, trucks and vans. Proposed costs will be reimbursed in accordance with an IRS compliant depreciation schedule. (Note: If most vehicles are assigned to a central/administrative office, identify one of the "Facility" columns as this office and enter all budgeted amounts under that column). Attach a description of the vehicle and documentation of price.

**Major Facility Repairs:** repairs to a facility other than minor "maintenance" expenses included in Schedule 4 (Occupancy Cost Justification). Attach documentation.

**Major Equipment Purchase:** major equipment purchased for use in delivering the service. Attach a description and documentation.

## SCHEDULE 8: CLIENT EXPENSE COST JUSTIFICATION

This Schedule details the proposed expenditures by the organization for “*client (child/youth) specific*” expenses to provide the planned services. Examples of client services are noted below.

**Emergency Food:** the cost of providing daily food/meals for the child/youth.

**Emergency Clothing:** the cost of purchasing clothing for the child/youth.

**Personal Incidentals:** the cost of items related to personal hygiene, cosmetics, over-the-counter medication, special dietary foods, baby supplies, high chairs, car seats and diapers.

**Medical (OTC):** costs are limited to purchase of over-the-counter medication and first aid supplies for child/youth. In general, medical services provided by a licensed professional are covered under the Title XIX *Medicaid* Program.

## SCHEDULE 9: COMMUNICATIONS COST JUSTIFICATION

This Schedule details the proposed expenditures by the organization for communications necessary to carry out the planned service.

Using one column for each proposed facility, enter the amounts budgeted for the following categories of communications costs:

**Telephone/Landline (staff):** telephone service to be used for delivering the identified service. This includes local and long distance service. (Note: If all telephone service is billed to a central/administrative office, and costs cannot be attributed to separate facilities, identify one of the 'Facility' columns as this office and enter all budgeted amounts under that column).

**Cellular Telephone Service (staff):** telephone service to be used for delivering the identified service. This includes local and long distance service. (Note: If all telephone service is billed to a central/administrative office, and costs cannot be attributed to separate facilities, identify one of the 'Facility' columns as this office and enter all budgeted amounts under that column).

**Internet Service:** charges associated with cable/Wi-Fi/satellite internet services.

**Postage:** charges associated with sending letters and packages as part of the delivery of this service.

**Delivery:** distributing packages or other goods related to delivery of this service. (In general, delivery is to be avoided when the mail is used).

**Copying:** duplication expenses associated the delivering the identified service.

## **SCHEDULE 10: OTHER DIRECT COST JUSTIFICATION**

This Schedule details the proposed expenditures by the organization for any other direct costs necessary to carry out the planned service not included on Schedule 1 thru 9 and 11.

Using one column for each proposed facility, enter the type of expenses and dollar amount. Attach a detailed program and cost justification.

## SCHEDULE 11: INDIRECT/OVERHEAD COST JUSTIFICATION

This Schedule details the amounts to be paid by the organization for indirect, overhead or other administrative costs related to carrying out the planned service. The portion of indirect costs allocable to each of these potential program and/or funding sources must be posted in the appropriate column/cell.

If your agency has an approved (DC, state or federal) Indirect Costs Rate, the Indirect Costs Rate may be applied in this schedule. A copy of the most current approval letter detailing the costs included in the Indirect Costs Rate must accompany this schedule. Costs included in the approved Indirect Cost Rate may not be included in Schedules 1 thru 10.

Using one column for each proposed facility, enter the amounts budgeted for the following categories of indirect/overhead cost:

**Administration:** general organizational administration not associated with carrying out the specific service. This typically includes the salary, fringe benefits and overhead associated with a central administrative office. It includes a variety of activities not identifiable with program functions, but which are indispensable to their conduct and to the organization's corporate existence.

**Financial Management:** the services of a qualified accountant and/or bookkeeper necessary to carry out the identified service. (Note: If financial management services are included in the "Administration" line, above, leave this line blank).

**Audit:** the services of a qualified auditing organization to determine that all-accounting principles were followed in managing the finances associated with delivering the identified service. (Note: If audit services are included in the "Administration" or "Financial Management" lines, or in Schedule 3-Consultants/Experts, leave this line blank).

**Other Overhead:** any other overhead costs required for delivering the identified service, which cannot be classified in one of the above three indirect/overhead categories, or in Schedule 1 thru 10. Attach explanation and documentation.

## BUDGET SUMMARY

Columns 1 thru 11 of the Costs Schedules (1 thru 11) are summarized on the Budget Summary. These columns will populate upon the accurate completion of Columns 1 thru 11 on Schedules 1 thru 11. Should the Budget Summary not populate correctly, please post the column totals from each Schedule to the appropriate column/cell on the Budget Summary.

**Total Proposed Contract Costs:** The total cost of the proposed contract to provide the proposed services for the children and youths to be served.

**3% For-Profit Fee (if applicable):** For-profit entities are allowed to be reimbursed three percent (3%) of the actual reported/documented cash expenditures for the items of cost detailed in Schedule 1 thru 11. To establish the proposed budgeted costs of this program, for-profit entities are allowed to enter a fee of three percent (3%) of the total cost of the proposed service costs (the sum of Schedules 1 thru 11).

*“Not-For-Profit” entities must delete the formula from these column/cells to eliminate this additional fee.*

**Total Proposal Budget:** The total proposed budgeted costs to provide the services for the children and youths for the proposed contract. This is the sum of Schedules 1 thru 11, and if applicable, the 3% for-profit entity fee.

## HOURLY RATE CALCULATION WORKSHEET INSTRUCTIONS

Providers will be reimbursed for services via a negotiated hourly rate based on the number hours/units of service. The headings on the sheet should populate with the accurate completion of the "Cover Sheet". Should the heading fail to populate, please check (correct if necessary) your entries on the Cover Sheet.

- [A] **Total Budgeted Costs:** Should populate from the total of Column B "Total Program Costs" on the Budget Summary worksheet. Should the space fail to populate, please enter the amount indicated as the "Total Budget" in Column B "Total Program Costs" on the Budget Summary
- [B] **Proposed Hourly Units of Service:** Enter the number hourly units proposed to serve.
- [C] **Projected Hourly Rate:** The pre-set formula will calculate the hourly rate. The pre-set formula is [=SUM(G12/C21)].

PRIME CONTRACTOR INFORMATION:	
Company: _____ Street Address: _____ City & Zip Code: : _____ Phone Number: _____ Fax: _____ Email Address: _____	Solicitation Number: _____ Contractor's Tax ID Number: _____ Caption of Plan: _____ _____ _____
Project Name: _____ Address: _____ _____ Project Descriptions: _____ _____ _____	Duration of the Plan: From _____ to _____ Total Prime Contract Value: \$ _____ Amount of Contract (excluding the cost of materials, goods, supplies and equipment) \$ _____ Amount of all Subcontracts: \$ _____ LSDBE Total: \$ _____ equals _____ % <div style="display: flex; justify-content: space-between; width: 100%;"> <span>LSDBE Subcontract Value</span> <span>Percentage Set Aside</span> </div>

(List each subcontractor at any tier that will be awarded a subcontract to meet your total set aside goal.)

SUBCONTRACTOR INFORMATION: (use continuation sheet for additional subcontracts)										
Name	Address & Telephone No.	Type of Work	NIGP Code(s)	Description of Work						
Total Amount Set Aside: \$ _____ Percentage of Total Set Aside Amount : _____ %    Tier: : _____ <span style="margin-left: 150px;">1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup></span>			Point of Contact: _____ <span style="margin-left: 150px;">Name (Print)</span>							
LSDBE Certification Number: _____ Certification Status: (check all that apply) <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 30px;">SBE:</td> <td style="width: 30px;">LBE:</td> <td style="width: 30px;">DBE:</td> <td style="width: 30px;">DZE:</td> <td style="width: 30px;">ROB:</td> <td style="width: 30px;">LRB:</td> </tr> </table>			SBE:	LBE:	DBE:	DZE:	ROB:	LRB:	Contact Telephone Number: _____ Fax Number: _____ Email Address: _____	
SBE:	LBE:	DBE:	DZE:	ROB:	LRB:					

**CERTIFICATIONS**

The prime contractor shall attach a **notarized** statement including the following:

- a. A **description of the efforts** the prime contractor will make to ensure that LBEs, DBEs, ROB, SBEs, LRBs, or DZEs will have an equitable opportunity to compete for subcontracts;
- b. In all subcontracts that offer **further subcontracting opportunities**, assurances that the prime contractor will include a statement, approved by the contracting officer, that the subcontractor will adopt a subcontracting plan similar to the subcontracting plan required by the contract;
- c. **Assurances** that the prime contractor will cooperate in any studies or surveys that may be required by the contracting officer, and submit periodic reports, as requested by the contracting officer, to allow the District to determine the extent of compliance by the prime contractor with the subcontracting plan;
- d. Listing of the type of **records** the prime contractor will maintain to demonstrate procedures adopted to comply with the requirements set forth in the subcontracting plan, and include assurances that the prime contractor will make such records available for review upon the District's request; and
- e. A description of the prime contractor's recent **efforts to locate LBEs, DBEs, SBEs, DZEs, LRBs, and ROB, and to award subcontracts to them.**

PERSON PREPARING THE SUBCONTRACTING PLAN:	
Name: _____ <span style="margin-left: 150px;">(Print)</span> Telephone Number: (    ) _____ - _____ Fax Number: (    ) _____ - _____ Email Address: _____	Signature: _____ Title: _____ Date: _____

**FOR CONTRACTING OFFICER USE ONLY**

Date Plan Received by Contracting Officer: _____	
Report: <input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable	Contract Number: _____
Name & Title of Contracting Officer _____	Signature _____ Date _____

(SUBCONTRACTORS LIST CONTINUED)

(List each subcontractor that will be awarded a subcontract to meet your total set aside goal.)

SUBCONTRACTOR INFORMATION: (use continuation sheet for additional subcontracts)										
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SBE:	LBE:	DBE:	DZE:	ROB:	LRB:					

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Human Care Agreement

Mental Health Services

Contract No. DCRL-2013-R-0083

Friday, May 24, 2013

11:00 A.M.

Name	Company	Phone	Fax	Email
P.T. Brown		703.401.5983		ptb@psych @hotmail.com
Regina Stanley	CTC	301 386 2991413		RAostanley@ aol.com
Ramona Stoltz	Florian Selections	202. 333.1232		ramona@ florianselections.com
Bonita Wilcox	JMD Counseling	39 613 3847		Bonita.jo@ gmail.com
Abnanta Kundere	Vicare, LLC	202 779 5440		vcareakiridena@ gmail.com
Patrick Crawford	C.C.M.H.S	301-341-5111	3/341-5211	patrick.crawford@ crawfordconsulting.org
Leslie Palmer	C.C.M.H.S.	(240) 277-0894		lpalmer@crawfordconsulting .org
Tricia Farghansu	CCMHS	240-731-9416		
Patricia Eyster	The Stixrud Group	301-565- 0534		peyster@stixrud. com
Greg Clark	Catholic Charities	301-635- 5992		greg.clark@ catholiccharitiesdc.org
Nancy Blackwell	CFS	(240) 275-1957		jmonroejr @mac.com

Human Care Agreement

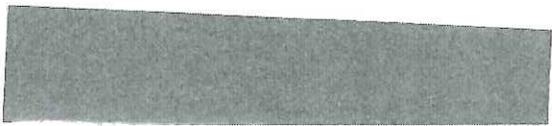
Mental Health Services

Contract No. DCRL-2013-R-0083

Friday, May 24, 2013

11:00 A.M.

Name	Company	Phone	Fax	Email
Freedom Dewey	Practicing Student Support SCS LLC	202 510 4192	202 835 0080	Dr.freedom@atlq.com
Mark LeVota	Catholic Charities	202 772-4340	202 772-4407	Mark.LeVota@CatholicCharitiesDC.org
Elaine Morris	API	2/291/0912	2/291/9680	emorris@apiassociatesinc.com
Yanique L. Walker	API	"	"	ylockhart-walker@apiassociatesinc.com
Dr. Janna Williams	API	202/291/0912	2/291/9680	jwilliams@apiassociatesinc.com
Michelle Marie Johnson	PSA	707 77683		
Alexander Wilson	The Lindsay Group LLC	202 390 8205	"	awilson@thelindsaygroupllc.com
Dr. Brewer	MPB Group	410 730 2385	866 371 5933	doctor_brewer@mpbgroupinc.com
John Kanya	MBI	202 215 5348	202 388-9209	jkanya@mbihs.com
Roger Tchoufa	MBI	202 <del>816</del> 374 8146	"	rtchoufa@mbihs.com
Territa Wilkinson	MBIB	202 388 2922	"	twilkinson@mbihs.com



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Austin Hicks YouthVillage 7/516-6957 7/516-6980 austin-hicks@youthvillage.org

Tara, Jerry, Shamika, Charlie, Trayshawn,  
Sandra GG, Kristal - CPSA attendees