Broward Behavioral Health Coalition, Inc.	
Policy Title: Agency Pre-Qualification	
Policy Number: BBHC.0087	**Contract Section (s): Contract No. JH343**
Effective Date: March 15, 2014	**Revision Date**: 8/4/2023
Responsible Department: Continuous Quality Improvement (CQI)	
Approved by: Caren Longsworth, Director of Quality Improvement Signature: Caren Longsworth (DocuSigned by: 7A4D59B701D0479...) Date: 8/6/2023 Approved by: Silvia Quintana, Chief Executive Officer Signature: Silvia Quintana (DocuSigned by: D999499950A143C...) Date: 8/6/2023	

Policy - Broward Behavioral Health Coalition, Inc. (BBHC) must subcontract behavioral health services, funded by the State of Florida, in a way that affords open competition. BBHC invites applicants to join its Provider Network when a need is identified whereby interested entities may apply to provide substance abuse or mental health services, or both, to adults and youth (persons under the age of 18). BBHC may contract with for-profit organizations when specific services are not available from non-profit or governmental organizations.

Purpose:

This Policy establishes:

1. The process, requirements, and procedures for entities seeking to enter the BBHC Provider Network, the evaluation of applications, and the necessary minimum requirements.

2. This policy will also set forth BBHC's Pre-Qualification criteria and provide appropriate direction to BBHC staff and interested applicants in applying for pre-qualification to the Provider Network.

Roles and Responsibilities

BBHC:

1. Shall ensure equitable access to the BBHC Provider Network when a need is identified.
2. BBHC will establish a schedule for review of each application that includes time to review all submitted written materials and the

site visit and is consistent with the Calendar of Events posted in the solicitation for applications.

3. Shall appoint a Network Management Development Committee to review all applications for Pre-Qualification. The committee shall be comprised of a minimum of three (3) representatives each of whom will possess experience in at least one (1) of the following areas: public procurement and contract negotiation; 2) management of program development of behavioral health services; or 3) finance or accounting.
4. Shall provide sufficient oversight to ensure the Network Management Development Committee shall operate independent of outside influence and adhere to applicable policies and procedures.

5. Shall ensure adherence to the pre-qualification process and establish a Schedule of Events for any Pre-Qualification solicitation.

6. Shall review the written recommendations of the Network Management Development Committee which shall recommend each applicant to be found either 1) pre-Qualified; or 2) Declined.

7. Submit the recommendation to the BBHC Board of Directors for final approval.

Network Management Development Committee

1. Shall convene meetings in accordance with §§286.011 and 286.0113, Florida Statutes, as may be amended from time to time, to consider applications submitted in response to a BBHC Request for Applications (RFA).

2. Shall recommend each applicant to be found either 1) Pre-Qualified; or 2) Declined. This will be forwarded to the BBHC Management Team.

Appeals Panel

1. Shall receive and review all appeals to determine whether a procedural flaw was present in the application review process.

2. Shall offer a written final recommendation on application to the BBHC CEO.

BBHC's Provider Relations Department

1. Shall develop a file maintenance system for all approved applications for pre-qualification.

2. During the contract negotiation process between the provider and BBHC, the provider will be required to update application materials, as needed, prior to entering a contract with BBHC.

3. For those successful applicants who are recommended to be included within BBHC's provider network, BBHC will assist the applicant with meeting applicable accreditation standards, if the provider is not accredited at the time of Pre-Qualification, prior to being awarded a contract.

PROCEDURES

Application Elements

1. Applications for Pre-Qualification will be accepted in response to a Request for Applications, Request for Proposal, or Request for Letters of Interest during a BBHC open enrollment period listed in the applicable advertised solicitation.

2. Only a timely, complete, and responsive application for Pre-Qualification will be considered by Network Management Development Committee. A complete application includes an answer for each item, the required supporting documentation and information submitted by the closing deadline posted in the solicitation. No exceptions will be considered or granted. By submission of the application for Pre-Qualification, each Applicant agrees, if awarded funding by BBHC, it will: 1) adhere to the requirements contained in any future awarded BBHC contract; 2) co-brand materials will be distributed and made available to its prospective, and admitted clients, as well as the general public; 3) services provided will be evaluated by BBHC in accordance with the Performance Measures included in the BBHC subcontract; and 4) understanding and agreement that successful applications for Pre-Qualifications are not a guarantee of contract or funding, and additional negotiation may be conducted by BBHC to determine the best value for BBHC and its clients.

3. Required Documents – The application of Pre-Qualification contains a list of questions and documents the applicant must complete as part of its response. For any question or document an Applicant determines to be "Not Applicable" the agency must submit a justification clearly explaining why the item is not applicable or the submittal may be deemed incomplete and non-responsive. Items subsequently determined by the Network Development Committee to be applicable and for which the Applicant did not include the required submittal will result in the application being considered non-Responsive. Additional documents may be required as contained in the solicitation.

4. E-Verify Registration and Use.
   A. Pursuant to section 448.095, Florida Statutes, beginning January 1, 2021, Contractors shall register with and use the U.S. Department of Homeland Security's E-Verify system, https://e-verifv.uscis.aov/emp.

orization status of all Contractor employees hired on and after January 1, 2021.

B. Subcontractors (i) Contractor shall also require all subcontractors performing work under this Agreement to use the E-Verify system for any employees they may hire during the term of this Agreement. (ii) Contractor shall obtain from all such subcontractors an affidavit stating the subcontractor does not employ, contract with, or subcontract with an unauthorized alien, as defined in section 448.095, Florida Statutes. (iii) Contractor shall provide a copy of all subcontractor affidavits to the City upon receipt and shall maintain a copy for the duration of the Agreement.

C. Contractor must provide evidence of compliance with section 448.095, Florida Statutes. Evidence shall consist of an affidavit from the Contractor stating all employees hired on and after January 1, 2021, have had their work authorization status verified through the E-Verify system and a copy of their proof of registration in the E-Verify system.

D. Failure to comply with this provision is a material breach of the Agreement and shall result in the immediate termination of the Agreement without penalty to the City. Contractor shall be liable for all costs incurred by the City to secure a replacement Agreement, including but not limited to, any increased costs for the same services, any costs due to delay, and rebidding costs, if applicable.

Application Process

BBHC may accept applications from entities interested in being included within the Provider Network when BBHC determines it needs to fill a void in the behavioral health service needs within the community. The review of applications consists of two (2) components: 1) Review of the *application for Pre-Qualification* and required documents as specified in this Policy and any subsequent solicitation; and 2) a site visit to the provider's place of business at which it will be providing contracted services to the community.

1. <u>Review of Application for Pre-Qualification and Required Documents</u>
   The Network Management Development Committee will conduct a substantive review and assessment of the applicant's credentials and documentation to assess the applicant's administrative, fiscal, and programmatic policies and procedures; financial stability; current certification and accreditation status, licenses, corporate status, treatment outcomes, and recipient satisfaction that exemplifies a reasonable likelihood of its capacity to meet BBHC's contractual requirements and quality expectations throughout the term of any awarded contract.

   If at any time during the review a finding is identified that may result in an applicant not being pre-qualified, the review may be immediately suspended or terminated at the discretion of the Network Management

The application may be determined to be non-responsive on this basis.

Reviewers may: interview administrative and clinical staff, as well as consumers; validate the Administrative and Fiscal Self-Evaluation Form completed by the applicant; conduct a walk-through of applicant's facility; verify the information in the application; and determine compliance with rules and regulations applicable to the services, which the organization is requesting to be pre-qualified.

2. The Site Visit

   a. The Provider Relations Department, in collaboration with the Network Management Development Committee will conduct a site visit of Applicants' operations. BBHC may waive the Site Visit for current pre-Qualified members of the BBHC Provider Network who re-apply for Pre-Qualification.

   b. Applications will not be considered for those applicants who decline a site visit. The site visit will be scheduled by the Provider Relations Department and conducted after the close of the application period. Applicants will receive five (5) business days' notice of the date of the scheduled site visit.

Application Review

1. It is the responsibility of the Applicant to ensure its submission meets the posted deadlines and requirements. All applications are to be submitted as required in the applicable solicitation. Applications will be opened on the advertised date and thereafter reviewed for consideration following the posted deadline when a meeting of the Network Management Development Committee can be scheduled.

2. The Network Management Development Committee shall work independently and consider only the criteria established by BBHC in its solicitation for applications and applicable policies and procedures.

3. Provider Relations shall review each application for Pre-Qualification to determine its responsiveness in submitting the required materials.

4. Provider Relations shall return to the applicant any application submitted past the deadline or determined to be non-responsive within five (5) business days following the deadline. These applications will not be opened or considered.

5. Provider Relations shall forward each application for Pre-Qualification that contains the required elements to the Network Management Development Committee.

Development Committee shall forward its written recommendations for each applicant to the BBHC Chief Executive Officer. The Committee shall offer one (1) of two (2) recommendations: Pre-Qualified or Declined.

7. Successful applications for Pre-Qualification deemed to be pre-Qualified will be valid for the length of the contract entered into with BBHC so long as the provider remains in good standing. BBHC reserves the right to void Pre-Qualification determination without cause.

Notice of Pre-Qualification

1. BBHC shall provide written notice of applicants accepted into the BBHC Provider Network through an electronic posting on the BBHC website (www.bbhcflorida.org) by the date posted in the solicitation of applications Calendar of Events.

2. Each successful applicant must provide written acceptance of its Pre-Qualification to BBHC's Management Team within thirty (30) calendar days of posting of notice on the BBHC website.

3. Unsuccessful applicants may submit a written appeal to BBHC.

REFERENCES:
BBHC Procurement Policy; State of Florida Pamphlet 155-2, 65 E-14 F.A.C. and in the Attachments and Exhibits of the BBHC Contract and Provider Contract Handbook.

ATTACHMENTS:

1. Application for Pre-Qualification
2. Administrative and Fiscal Self-Evaluation
3. Debarment/Suspension Statement
4. E-Verify Procurement Affidavit
5. Working Agreement for SSI/SSDI – SOAR Initiative
6. Certification of Prohibition of Lobbying
7. Civil Rights Compliance Form
8. Mandatory Assurances
9. CLAS Plan Information
10. Program Description
11. Controlling Interest Form (Applicable only to for-profit organizations)

DEFINITIONS:

REVISION LOG

REVISION	DATE
Transferred to a BBHC Policy	6/29/2020
Reviewed, no changes made	7/20/2021
Reviewed, no substantial changes made	7/28/2022

davit verbiage and attachment	3/14/2023
Reviewed, grammatical changes made	8/4/2023

The Director of Quality Improvement and Chief Executive Officer are responsible for all content in this policy.

Application for Pre-Qualification (Form PR003-001)

Applicants are discouraged from submitting information considered confidential and proprietary unless it is deemed essential for the proper evaluation of the Application. If the Application contains information the Applicant considers to be trade secrets; information that is financial; or information that is privileged or confidential; then, the specific pages containing such information shall be clearly marked. It is understood by all parties, the information submitted as part of this Application for Pre-Qualification is not confidential and may be disclosed to the extent authorized by law.

Please complete a response for each item. Any answer of **Not** Applicable requires a detailed explanation/justification attached to this Application.

Applicant Agency Name: _____

Authorized Agency Official (AAO) Name: _____

AAO Title: _____ **Email:** _____

Corporate Address: _____

_____

Applicant Phone Number: _____ **Applicant Website:** _____

Service County: _____

Tax ID Number: _____ **NPI Number:** _____

In order to expedite the Review process, please complete and sign all the items required in this Application for Pre-Qualification including the attestation of accuracy. All items listed below must be submitted as part of this Application. Any items not completed or submitted will be returned without review and determined non-responsive.

- ☐ Application for Pre-Qualification
- ☐ Mandatory Assurances
- ☐ Working Agreement for SSI/SSDI Outreach, Access, and Recovery (SOAR)
- ☐ Certification Regarding Lobbying
- ☐ Civil Rights Compliance Questionnaire
- ☐ Administrative and Fiscal Self Evaluation
- ☐ Agency Operating Budget
- ☐ Certification of Debarment, Suspension, Ineligibility, and Voluntary Exclusion
- ☐ Current Accreditation Certificate ☐ Not Applicable
- ☐ Medicare Acceptance Letter ☐ Not Applicable
- ☐ State License(s) ☐ Not Applicable

☐ Signed and completed Ownership/Controlling Interest Form; ☐ Not Applicable

☐ Proof of Insurance (employment, general, professional, malpractice, property, etc.)

☐ W9 Form

☐ Practitioner Roster (full name; NPI; license; service location; service department) ☐ Not Applicable

☐ Certificate of Status from the Florida Department of State

☐ Articles of Incorporation (N/A for government entities)

☐ Most recent Audit and Management Letter (if applicable) with an unqualified opinion and no findings of material weakness; **Fiscal Year End**: _____

☐ Board of Directors Roster (term, email, affiliation)

☐ Board of Director Meeting Schedule and previous two Meeting Minutes

☐ Agency Bylaws

☐ Letter of Support; (optional)

☐ IRS Form 990

☐ Roster of Other Funders and list of all deficiencies/findings for the previous two (2) year period and status of correction ☐ Not Applicable

☐ Copy of each executed subcontract/**excerpt with services overview** and Memoranda of Understanding related to delivery of client services ☐ Not Applicable

☐ Sliding Fee Scale ☐ Not Applicable

☐ Client Trust Fund procedures ☐ Not Applicable

☐ Quality Assurance / Improvement Plan

☐ Informed Consent Form

☐ Service Plan and related Policy

☐ Treatment Plan and related Policy

☐ Client Record example

☐ Incident Reporting Policy

☐ Grievance and Complaint Policy

☐ Emergency Preparedness Plan/Continuity of Operations Plan

☐ Table of Organization

☐ Resume/Curriculum Vitae for CEO/Executive Director; Clinical Director; Program Director; and Finance Director

☐ Financial Eligibility Screening procedures

☐ Cultural and Linguistic Plan and

☐ Code of Ethics

Applicant Agency Legal Status

☐ Not – For – Profit (include certification of status from the U.S. Internal Revenue Service

☐ Government Organization

☐ For-Profit

Federal Employer Identification Number (FEID):_____

TYPE OF ORGANIZATION (Check all that apply)

☐ Home Health Agency

☐ Hospital

☐ Community Mental Health Center

☐ Skilled Nursing Facility/Nursing Home

☐ Substance Abuse Treatment

☐ Other Inpatient Facility

☐ Other _____

CERTIFICATION AND LICENSURE (Please attach copies to this application)

	Certificate or License Number	Expiration Date
Medicare	_____	_____
Medicaid	_____	_____
State License	_____	_____
JCAHO	_____	_____
CHAP	_____	_____
AAAHC	_____	_____
CARF	_____	_____
ACHC	_____	_____
HFAP/AOA	_____	_____
COA	_____	_____

Restrictions:

Please list any license sanctions or regulatory agency sanctions:

_____

_____

SERVICE LOCATION(S)*: (Please attach list of additional service locations)

Facility Name (Location 1): _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Coordinator: _____ Email: _____

Hours of Operation: :_____ After Hours Contact Number:_____

Population Served: ☐ Infants(0-3) ☐ Preschool(0-5) ☐ Children(6-12) ☐ Adolescents(13-18)

☐ Adults ☐ Geriatrics

Beds: ☐ Adults ☐ Children ☐ Geriatrics ☐ Male ☐ Female

Total Bed Capacity: _____

Outpatient Services (Check all that apply): ☐ Mental Health Psychotherapy ☐ Substance Abuse Psychotherapy ☐ Group Therapy Mental Health ☐ Group Therapy Substance Abuse ☐ Medication Management ☐ Psych Testing ☐ IOP Mental Health ☐ IOP Substance Abuse ☐ PHP Mental Health ☐ PHP Substance Abuse ☐ Other:_____

Inpatient Services (Check all that apply): ☐ Crisis Stabilization Unit Mental Health ☐ Crisis Stabilization Unit Substance Abuse ☐ Addictions Receiving Facility (ARF)/Juvenile Addictions Receiving Facility (JARF) ☐ 24-hour Treatment Observation ☐ Mental Health ☐ Substance Abuse ☐ Detox ☐ Rehabilitation ☐ Residential (Substance Abuse) ☐ Residential (Mental Health) ☐ Residential (Co-Occurring) ☐ Long Term Care ☐ Other:_____

Facility Name (Location 2)**:** _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Coordinator: _____ Email: _____

Hours of Operation:_____ After Hours Contact Number:_____

Population Served: ☐ Infants(0-3) ☐ Preschool(0-5) ☐ Children(6-12) ☐ Adolescents(13-18)

☐ Adults ☐ Geriatrics

Beds: ☐ Adults ☐ Children ☐ Geriatrics ☐ Male ☐ Female

Total Bed Capacity: _____

Outpatient Services (Check all that apply): ☐ Mental Health Psychotherapy ☐ Substance Abuse Psychotherapy ☐ Group Therapy Mental Health ☐ Group Therapy Substance Abuse ☐ Medication Management ☐ Psych Testing ☐ IOP Mental Health ☐ IOP Substance Abuse ☐ PHP Mental Health ☐ PHP Substance Abuse ☐ Other:_____

Inpatient: Services (Check all that apply): ☐ Crisis Stabilization Unit Mental Health ☐ Crisis Stabilization Unit Substance Abuse ☐ Addictions Receiving Facility (ARF)/Juvenile Addictions Receiving Facility (JARF) ☐ 24-hour Treatment Observation ☐ Mental Health ☐ Substance Abuse ☐ Detox ☐ Rehabilitation ☐ Residential (Substance Abuse) ☐ Residential (Mental Health) ☐ Residential (Co-Occurring) ☐ Long Term Care ☐ Other:_____

Facility Name (Location 3):_____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Coordinator: _____ Email: _____

Hours of Operation:_____ After Hours Contact Number:_____

Population Served: ☐ Infants(0-3) ☐ Preschool(0-5) ☐ Children(6-12) ☐ Adolescents(13-18)

☐ Adults ☐ Geriatrics

Beds: ☐ Adults ☐ Children ☐ Geriatrics ☐ Male ☐ Female

Total Bed Capacity: _____

Outpatient Services (Check all that apply): ☐ Mental Health Psychotherapy ☐ Substance Abuse Psychotherapy ☐ Group Therapy Mental Health ☐ Group Therapy Substance Abuse ☐ Medication Management ☐ Psych Testing ☐ IOP Mental Health ☐ IOP Substance Abuse ☐ PHP Mental Health ☐ PHP Substance Abuse ☐ Other:_____

Inpatient: Services (Check all that apply): ☐ Crisis Stabilization Unit Mental Health ☐ Crisis Stabilization Unit Substance Abuse ☐ Addictions Receiving Facility (ARF)/Juvenile Addictions Receiving Facility (JARF) ☐ 24-hour Treatment Observation ☐ Mental Health ☐ Substance Abuse ☐ Detox ☐ Rehabilitation ☐ Residential (Substance Abuse) ☐ Residential (Mental Health) ☐ Residential (Co-Occurring) ☐ Long Term Care ☐ Other:_____

CONTACT INFORMATION

Title	Name	Phone Number	Email address
CEO/Executive Director			
Quality Officer			
Program Director			
Data Security Officer			
HIPAA Privacy Officer			
Clinical Director			
Finance Director/CFO			

Name of Electronic Healthcare Record: _____

Applicant Mission Statement (50 words of less):

The following requires no more than one (1) page response:

1. **Describe the Executive Management structure, including key positions and each function. Include how each of these positions will any effort related to a future contract award by BBHC.**

2. **Provide a description of the role the services the Applicant provides in the community and how these services integrate to both the Behavioral Health System of Care and other systems of care. D e s c r i b e any independent or Applicant funded studies, reports, or analysis to support service delivery catchment area and the need for expansion of this service(s) by BBHC. If the Applicant's services are part of a "formally" established continuum of care within a system of care, describe the continuum of care, system of care, its features for enhancing the services, target population served, and the Applicant's roles and responsibilities within this system of care. Applicant's may attach executed agreements formalizing collaboration with other stakeholders within the system of care.**

3. **Describe the Applicant Referral Process (*obtaining* referrals for your services; and how to *make* referrals). Indicate any formal or informal agreements you may have with other entities, or individuals, from whom you receive referrals and who make referrals to you.**

4. **Briefly describe the computer system's hardware and software. Describe your system for capturing and reporting client demographic information, assessment and placement information, services and units of service provided, and outcome data. The description must include a discussion on your ability to comply with the data requirements contained in DCF's PAM 155-2, most current edition, including a determination whether you are able to immediately comply, the amount of time to revise your system in order to comply, and the cost associated with compliance.**

5. **Describe your agency's strategies and tactics employed to educate the community of services provided by your agency and to ensure access to available services.**

6. **Please detail the Applicant's procedures to ensure access to services by persons with disabilities.**

7. **Please detail how the Applicant will promote individual and family living, working, learning, and socializing. Discuss how the Applicant employs person-centered language and the involvement of individuals and families in the planning, development, and implementation and evaluation of all aspects of this service delivery system.**

8. **Please describe the practices utilized by the Applicant to ensure individual and family participation.**

ATTESTATION:

I attest and certify I have answered the above application questions truthfully and that information given in or attached to this application is accurate and completed to the best of my knowledge. I understand as a condition to making this application, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for rejection of my request for participation with Broward Behavioral Health Coalition, Inc.

Recipients of BBHC contracted funds must adhere to all applicable state and federal statutes, regulations, and policies, and BBHC policies and requirements. The Applicant is expected to be in compliance with applicable local laws and ordinances.

Anyone who becomes aware of the existence (or apparent existence) of fraud, waste, or abuse related to BBHC contracted funds is required to report this information to the BBHC Chief Executive Officer. This includes embezzlement, misuse, or misappropriation of contract funds, and false statements, whether by organizations or individuals, theft of contracted funds/BBHC property; and, submission of false reports.

BBHC may use administrative remedies when a successful applicant deliberately withholds information; submits fraudulent information; or does not comply with applicable requirements including revocation of award of pre-qualification; financial penalties in accordance with Section 402.73(7), F. S., and Section 65-29.001 F.A.C.; contract termination, with or without cause.

Signature:_____ Date: _____

Printed Name and Title:_____

FOR OFFICE USE ONLY - To be completed by Provider Services Department

- ☐ Site Visit Evaluation Form complete and enclosed (Site Visit Date:_____)
- ☐ Application is complete and signed (Preliminary Review Date:_____)
- ☐ Required documents submitted, current, and signed, if applicable

ADMINISTRATIVE AND FISCAL SELF-EVALUATION FORM
PR003-03

The completion of the Administrative and Fiscal Self Evaluation provides BBHC with assurances the Applicant has adequate administrative and financial procedures in place to ensure any funds disbursed by BBHC will be safeguarded as outlined in Chapter 287, Florida Statutes.

Please answer all questions by checking the applicable box. For those items that are not applicable to your organization, check N/A. If you need to provide additional information or cannot respond to a question, please attach an explanation on a separate page.

Please provide a brief explanation for any negative response.

I. SEGREGATION OF DUTIES

1.	Someone other than the timekeeper and persons who deliver paychecks to employees prepares the payroll.	☐YES	☐NO	☐N/A
2.	The duties of record keeper are separated from any cash related funds.	☐YES	☐NO	☐N/A
3.	Check signing is limited to those authorized to make disbursements and whose duties exclude posting and recording of cash received.	☐YES	☐NO	☐N/A
4.	Personnel performing the disbursement and whose duties exclude posting and recording of cash received.	☐YES	☐NO	☐N/A
5.	Mail receipts are opened and listed by someone not involved in posting transactions, deposit preparation and deposit making.	☐YES	☐NO	☐N/A
6.	The person making the deposit is different from the person who prepares the deposit.	☐YES	☐NO	☐N/A
7.	An official who is not responsible for its preparation and is outside the payroll department approves the payroll.	☐YES	☐NO	☐N/A

II. WRITTEN POLICIES AND PROCEDURES

1.	Record retention	☐YES	☐NO	☐N/A
2.	Travel and entertainment	☐YES	☐NO	☐N/A
3.	Purchasing	☐YES	☐NO	☐N/A
4.	Asset acquisition, inventory, and disposal	☐YES	☐NO	☐N/A
5.	Cash management (payables, receivables, deposits, petty cash, reconciliations, etc.)	☐YES	☐NO	☐N/A
6.	Credit cards	☐YES	☐NO	☐N/A
7.	Subcontractors	☐YES	☐NO	☐N/A

8.	Bad debt write-offs	☐YES	☐NO	☐N/A
9.	Disaster plan, including recovery	☐YES	☐NO	☐N/A
10.	Personnel	☐YES	☐NO	☐N/A
11.	Employee loans	☐YES	☐NO	☐N/A
12.	Client trust funds	☐YES	☐NO	☐N/A
13.	Computer back-up	☐YES	☐NO	☐N/A
14.	Recycling	☐YES	☐NO	☐N/A
15.	Data security	☐YES	☐NO	☐N/A

III. CASH

A. Cash Handling Procedures

1.	a. All revenue is deposited into one operating account b. Deposits are made on a ____ daily; ____ weekly; _____ other basis.	☐YES	☐NO	☐N/A
2.	The organization maintains a cash receipts journal.	☐YES	☐NO	☐N/A
3.	Revenue received that is not deposited on the same day is stored in a locked and secure location.	☐YES	☐NO	☐N/A
4.	The person receiving the monthly bank statement in the mail is not the same person responsible for performing the monthly account reconciliation.	☐YES	☐NO	☐N/A
5.	The bank statements and paid checks are received unopened from the bank by the person reconciling the account.	☐YES	☐NO	☐N/A
6.	Checks received in the mail are restrictively endorsed immediately upon opening the mail.	☐YES	☐NO	☐N/A
7.	Cash received from fund raising events are properly controlled, accounted, and reported.	☐YES	☐NO	☐N/A
8.	Bank reconciliations are performed monthly, reviewed, and signed by the next level of management.	☐YES	☐NO	☐N/A

B. Petty Cash

1.	A specific employee is designated, in writing, as custodian.	☐YES	☐NO	☐N/A
2.	Petty cash is not commingled with other funds and is used for small, emergency expenses.	☐YES	☐NO	☐N/A
3.	Cash funds are kept in a locked, secure location.	☐YES	☐NO	☐N/A
4.	Payments are made through vouchers that are completely and accurately filled out.	☐YES	☐NO	☐N/A

5.	Payments are supported by invoices or receipts.	☐YES	☐NO	☐N/A
6.	Cash payments are made under $50 (for small incidental purchases).	☐YES	☐NO	☐N/A
7.	Travel expenses or reimbursements are not made from petty cash.	☐YES	☐NO	☐N/A
8.	Documents are effectively canceled (marked paid) when expense is paid.	☐YES	☐NO	☐N/A
9.	Surprise audits are periodically performed and documented in writing.	☐YES	☐NO	☐N/A
10.	The size of the petty cash fund is adequate to meet emergency expenses.	☐YES	☐NO	☐N/A

IV. ACCOUNTS RECEIVABLE

1.	A detailed accounts receivable aging schedule is maintained by accounting.	☐YES	☐NO	☐N/A
2.	The accounts receivable aging schedule is reconciled to the general ledger monthly. If not, specify the time schedule.	☐YES	☐NO	☐N/A
3.	The organization has established accounts receivable write off procedures that:			
	a. Are properly documented	☐YES	☐NO	☐N/A
	b. Are approved by the President/Chief Executive Officer and the Board of Directors	☐YES	☐NO	☐N/A

V. ACCOUNTS PAYABLE

A. Disbursements

1.	The organization maintains an accounts payable ledger (workbook) for its operating account.	☐YES	☐NO	☐N/A
2.	During the payment process, the following are verified by management:			
	a. Checks are issued in sequence	☐YES	☐NO	☐N/A
	b. Voids are clearly documented and accounted for	☐YES	☐NO	☐N/A
	c. Multiple payments made to one payee during the month are researched	☐YES	☐NO	☐N/A
	d. Payments are based on original invoices	☐YES	☐NO	☐N/A
	e. Payments are approved by appropriate levels of management	☐YES	☐NO	☐N/A
	f. Back-up is timely & effectively cancelled (marked paid) upon payment (to prevent duplicate payments)	☐YES	☐NO	☐N/A
	g. The check amount and invoice amount agree	☐YES	☐NO	☐N/A
	h. Bills are timely paid	☐YES	☐NO	☐N/A

i. Payments to the Executive Director are countersigned by a Board member ☐YES ☐NO ☐N/A

j. Goods and services with a cost of $1500 or more are supported with a cost analysis price quotation or competitive bid unless the organization's policies and procedures require another method. If so, please specify. ☐YES ☐NO ☐N/A

For tax exempt providers ONLY, please answer Item K:

k. Sales tax is not being paid on purchases of goods or services. ☐YES ☐NO ☐N/A

B. Employee Expense Transactions

1. Expense reports/ vouchers are utilized. ☐YES ☐NO ☐N/A
2. All expenses are supported with original receipts. ☐YES ☐NO ☐N/A
3. The business profile of the expenses is clearly stated. ☐YES ☐NO ☐N/A
4. All conference expenses are pre-authorized and supported with an agenda, backup, and receipts as appropriate. ☐YES ☐NO ☐N/A
5. A mileage sheet is used to calculate and reimburse mileage expenses. ☐YES ☐NO ☐N/A
6. The mileage sheet contains information to include beginning and ending odometer readings, purpose, and destination. ☐YES ☐NO ☐N/A
7. All travel expenses reimbursed from state funding sources are paid in accordance with state rates as provided in 112.061, Florida Statutes. ☐YES ☐NO ☐N/A

C. Credit Card Transactions

1. The organization maintains a listing of who has credit cards and the corresponding credit card numbers. ☐YES ☐NO ☐N/A
2. The organization performs monthly reconciliations of credit card statements. ☐YES ☐NO ☐N/A
3. The organization has review procedures that are used to track and pay balances. ☐YES ☐NO ☐N/A
4. Cardholders or their designee(s) is not making personal purchases with the entity's credit card. ☐YES ☐NO ☐N/A
5. Corporate credit cards that are loaned to employees are controlled through a log indicating the date, person's name, purchase amount, and description. ☐YES ☐NO ☐N/A

D. Tax Payments

IRS Forms 941 and UCT are completed, submitted and paid timely. ☐YES ☐NO ☐N/A

VI. FINANCIAL REPORTING

1. Monthly financial statements are prepared. ☐YES ☐NO ☐N/A

These include the following:

a.	A statement of activities (income statement) listed by covered service	☐YES	☐NO	☐N/A
b.	A statement of financial condition/position (balance sheet)	☐YES	☐NO	☐N/A
c.	Budget variance report	☐YES	☐NO	☐N/A
2.	Support documentation for all journal entries made is retained.	☐YES	☐NO	☐N/A
3.	a. The organization performs a monthly closing	☐YES	☐NO	☐N/A
	b. Prepares a complete set of accounting books (general ledger, accounts payable journal, accounts receivable journal, etc.) on a monthly basis.	☐YES	☐NO	☐N/A
4.	The organization maintains a current chart of accounts which:			
a.	Allows for covered service accounting	☐YES	☐NO	☐N/A
b.	Tracks administration as a covered service	☐YES	☐NO	☐N/A
c.	Has a methodology to allocate indirect cost including administration	☐YES	☐NO	☐N/A
5.	An independent audit has been performed and the report submitted to the department within 180 days from the organization's fiscal year end or within 30 days of the organization's receipt of the audit report, whichever occurs first.	☐YES	☐NO	☐N/A
6.	The organization has an adequate recordkeeping system. The records are kept in a central location and are neat and organized.	☐YES	☐NO	☐N/A
7.	Organization management submits monthly financial statements to the Board of Directors.	☐YES	☐NO	☐N/A

VII. ASSETS AND PROPERTY

1.	An annual inventory is taken and recorded in writing.	☐YES	☐NO	☐N/A
2.	Property records are reconciled to the general ledger at least annually.	☐YES	☐NO	☐N/A
3.	Property/capital assets are recorded on an asset ledger with the following information:			
a.	sequential item number	☐YES	☐NO	☐N/A
b.	description	☐YES	☐NO	☐N/A
c.	funding sources	☐YES	☐NO	☐N/A
d.	purchase date and amount	☐YES	☐NO	☐N/A
e.	cost	☐YES	☐NO	☐N/A
f.	location	☐YES	☐NO	☐N/A
g.	condition	☐YES	☐NO	☐N/A

h. asset tag number (capital assets of $1000 or more) ☐YES ☐NO ☐N/A

4. Acquisitions and disposals are documented in writing. ☐YES ☐NO ☐N/A

5. If any leases for property and equipment exist, they are current and properly executed. ☐YES ☐NO ☐N/A

VIII. LOANS

1. If loans are made to employees, formal, signed agreements are secured and contain the following:
   a. Date loan made, amount, and maturity ☐YES ☐NO ☐N/A
   b. Terms and conditions regarding repayment ☐YES ☐NO ☐N/A
   c. Approval by the President/Executive Director ☐YES ☐NO ☐N/A
   d. Disclosure to the Board of Directors through an aging schedule or other report ☐YES ☐NO ☐N/A

2. If loans are being granted to officers and/or directors of the organization, please explain on separate attachment. ☐YES ☐NO ☐N/A
   Attachment # ____ included.

IX. PERSONNEL MANAGEMENT/PAYROLL

1. All personnel files contain the following:
   a. I-9 forms ☐YES ☐NO ☐N/A
   b. W-4 forms ☐YES ☐NO ☐N/A
   c. E-verify forms ☐YES ☐NO ☐N/A
   d. Annual evaluations (if required) ☐YES ☐NO ☐N/A
   e. Pay rates and changes are clearly documented and agree with the latest payroll register. ☐YES ☐NO ☐N/A
   f. Reference checks ☐YES ☐NO ☐N/A
   g. Security agreement forms (CF 114) if applicable ☐YES ☐NO ☐N/A
   1. All employees with access to DCF data through computer-related media have read and signed the CF 114 ☐YES ☐NO ☐N/A
   2. The custodian (NAME) for all CF 114 forms at the provider's location is _____.
   3. The forms are stored at the following sites: _____

2. a. Employees document their work hours through a time sheet or punch clock. ☐YES ☐NO ☐N/A
   b. The employee signed the time records. ☐YES ☐NO ☐N/A

c. The supervisor reviewed and signed the time records. ☐YES ☐NO ☐N/A

3. Non-exempt employees receive time and a half for all hours in excess of 40 per week. ☐YES ☐NO ☐N/A

4. Do any of your employees also have a contract with your organization? If yes, please explain in separate attachment. ☐YES ☐NO ☐N/A
Attachment #____included

X. INDIVIDUAL CLIENT TRUST ACCOUNTS FOR FEDERAL BENEFIT PROGRAMS (SSAI, SSA, VA)

1. An individual account is established and managed for each client with adequate procedures in place to track all transactions and reconcile at least monthly. ☐YES ☐NO ☐N/A

2. Able to verify that client deposits are made within two days of receipt of funds. ☐YES ☐NO ☐N/A

3. Receipts for expenditures are maintained and approved by an appropriate level of management with documentation of such purchases. ☐YES ☐NO ☐N/A

4. All transactions are supported with receipts that are kept in the client's file. ☐YES ☐NO ☐N/A

5. Documentation is maintained for

   a. Transaction dates ☐YES ☐NO ☐N/A

   b. Deposits ☐YES ☐NO ☐N/A

   c. Withdrawals ☐YES ☐NO ☐N/A

   d. Interest earned ☐YES ☐NO ☐N/A

   e. Service charges (only bank account charges permitted) ☐YES ☐NO ☐N/A

6. If any client's bank account/trust fund is in access of $2000 please explain in a separate attachment. ☐YES ☐NO ☐N/A
Attachment #____ included ☐YES ☐NO ☐N/A

7. Client trust funds are maintained in interest bearing accounts. ☐YES ☐NO ☐N/A

8. Client trust funds are established in an insured bank, credit union or savings & loan association. ☐YES ☐NO ☐N/A

XI. INSURANCE

1. The organization has comprehensive liability insurance. ☐YES ☐NO ☐N/A

2. All required insurance policies are current and in effect. ☐YES ☐NO ☐N/A

DECLARATIONS – TO BE COMPLETED

1. Please list any and all family or business relationships that exist between your board of directors, organization's principal officers, your organization's employees and independent contractors.

   _____
   _____
   _____
   _____

2. Please list any civil litigations pending against your organization. Include a statement as to the amount of each claim and whether such potential for loss is covered by insurance.

   _____
   _____
   _____
   _____

3. Are there any amounts or reports due to the Internal Revenue Service and any other taxing organization that have not been paid or filed? Specify amounts, reports, and due dates.

   _____
   _____
   _____
   _____

4. Please list any regulatory investigations that either occurred or are pending by any agency by which they are licensed, certified, or accredited?

   _____
   _____
   _____
   _____

5. Please list all persons and their titles currently authorized to sign contract(s) on behalf of your organization.

   _____
   _____
   _____
   _____

6. Please list your CPA and his or her office address or telephone number.

   _____
   _____
   _____
   _____

7. Has there been any change in structure/operations of your programs in the past twelve months? If yes, please describe in detail.

   _____
   _____
   _____
   _____

8. Has key staff turnover occurred in key managerial or clinical positions during the past twelve months? If yes, what are the affected positions and reasons for the turnover?

   _____
   _____
   _____

Additional Comment/Explanation may be added on a separate page attached to this document.

CERTIFICATION:

I hereby certify that the answers provided in this self-monitoring document are true and accurate to the best of my knowledge.

_____ _____
Signature – Executive Director or CEO Date

_____
Printed Name – Executive Director or CEO

ATTACHMENT 4

Working Agreement for SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative Community Provider Agency

The Applicant agrees it shall designate staff to successfully complete SOAR to ensure the following:

1. Participate in the SOAR Initiative to include the submission of SOAR web-based data outlined in this Working Agreement.

2. Contact the identified Social Security Administration (SSA) liaison according to the Applicant's United States Postal Office zip code, and create an individualized application submission procedure that will be utilized for all initial SOAR applications. The procedure shall include the agreed upon preferred method of communication with the SSA liaison and how the protective filing date will be established for each claim.

3. Shall submit claims for SOAR applicants within two (2) weeks of the notification.

4. Complete and submit a Form SSA 1696 Appointment of Representative listing the name of the individual and the agency that will serve as the SOAR claimant's representative. This form will be submitted with the application.

5. Follow up on any additional needed non-medical information for SSA within two (2) business days of notification of the need for information. This follow-up will either provide the documentation needed or notify SSA of the steps being taken to obtain the notification.

6. Receive notification from the SSA claims representative once the claim has cleared the non-medical process and has been sent to the Division of Disability Determinations (DDD). This notification will take place within 24 hours of sending the claim to the DDD.

7. Obtain all existing medical information and submit it to the DDD, once the application for SSI/SSDI is complete.

8. Contact the DDD office within one (1) week of notification of the claim having gone to the DDD to determine who the disability adjudicator is and make contact by phone with that adjudicator, notifying him/her of working with a SOAR claimant, confirming the authorized representative status, and informing the examiner of the records being collected.

9. Maintain contact with the DDD adjudicator as appropriate, to check on the status of the claim and to continue to submit information.

10. Submit all existing medical information and additional evaluation information to the DDD within 30 calendar days of the submission of the application to the DDD by SSA.

11. Submit the medical summary report to the DDD within 30 calendar days.

12. Collect data regarding SOAR applications and submit it on an ongoing basis, via the Policy Research Associates' (PRA) web-based data entry program.

_____ _____

Executive Director *(Print Name)* **Applicant Agency**

_____ _____

Signature **Date**

Attachment 5

CERTIFICATION REGARDING LOBBYING
(Form PR003-06)

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require the language of this certification be included in any subsequent contract, grant, loan, or cooperative agreement award document(s) for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____ _____
Signature Date

_____ _____
Name of Authorized Individual Application/Contract Number

_____
Name of Organization

_____
Address of Organization

Clear

Contract No. _____

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987 Federal Register (52 Fed. Reg., pages 20360 - 20369).

INSTRUCTIONS

1. Each provider whose contract/subcontract equals or exceeds $25,000 in federal moneys must sign this certification prior to execution of each contract/subcontract. Additionally, providers who audit federal programs must also sign, regardless of the contract amount. The Department of Children and Families cannot contract with these types of providers if they are debarred or suspended by the federal government.
2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.
3. The provider shall provide immediate written notice to the contract manager at any time the provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms “debarred”, “suspended”, “ineligible”, “person”, “principal”, and “voluntarily excluded”, as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the department’s contract manager for assistance in obtaining a copy of those regulations.
5. The provider agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.
6. The provider further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal moneys, to submit a signed copy of this certification.
7. The Department of Children and Families may rely upon a certification of a provider that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.
8. This signed certification must be kept in the contract manager’s contract file. Subcontractor’s certification must be kept at the provider’s business location.

CERTIFICATION

(1) The prospective provider certifies, by signing this certification, that neither she nor his/her principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective provider is unable to certify to any of the statements in this certification, such prospective provider shall attach an explanation to this certification.

_____ _____
Signature Date

_____ _____
Name (type or print) Title

If desired, enter page number here.

DCF OFFICE OF CIVIL RIGHTS COMPLIANCE CHECKLIST

[To see "INSTRUCTIONS," click paragraph symbol ¶ on standard toolbar at top of your computer screen.]

Provider Name		County	Region/Circuit
Corporate Mailing Address			
City, State, Zip Code			Main Telephone Number
DCF Contract(s) Number(s)	Total Contract(s) amount $	Total amount of federal funding $	Total amount of state funding $
Are any of the contract numbers listed above a multi-year contract? If yes, state which one(s) and contract period.			
Completed By (name and title)		Telephone Number	Date Completed

PART I.

1. Describe the geographic area served and the type of service(s) provided:

2. Population of Area Served. List source of data:

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male

3. Staff Currently Employed. Effective date:

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled

4. Number of Clients Participating or Served. Effective date:

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled

5. Advisory or Governing Board, if applicable.

Total #	% White	% Black	% Hispanic	% Other	% Female	% Male	% Disabled

PART II. (Use a separate sheet of paper for any explanations requiring more space.)

6. Compare staff composition (#3) to population of area served (#2). Is staff representative of the population served? If No or NA, please explain.	☐ Yes ☐ No ☐ NA
7. Compare client composition (#4) to population of area served (#2). Are race/sex composition representative of populations served? If NO or NA, please explain.	☐ Yes ☐ No ☐ NA
8. Do you inform employees, applicants, and clients of their protection against discrimination in employment practices and in the delivery of services? If YES, how (verbal, written, poster)? If NO or NA, please explain.	☐ Yes ☐ No ☐ NA
9. Do recruitment and notification materials advise applicants, employees and clients of your non-discrimination policy? If NO, please explain.	☐ Yes ☐ No ☐ NA
10. Do you have a grievance/complaint policy or procedure receive, investigate and resolve complaints regarding employment decisions and provision of services to clients? If NO, please explain.	☐ Yes ☐ No ☐ NA
11. Does your grievance/complaint policy or procedure notify your employees and clients of their right to file a complaint with the appropriate external agency and provide contact information for these agencies (DOJ, HHS, EEOC, DCF)? If NO, please explain.	☐ Yes ☐ No ☐ NA

12. If applicable, does your grievance/complaint policy incorporate due process standards and provide for the prompt and equitable resolution of complaints alleging a violation of Section 504 of the Rehabilitation Act of 1973 (disability in employment practices and the delivery of services)? *[Applicable to providers with 50 or more employees and $25,000 or more in DOJ funding.]* If NO, please explain.	☐ Yes ☐ No ☐ NA

PART III. (Use a separate sheet of paper for any explanations requiring more space.)

13. Provide the number and status of any service delivery and employment discrimination complaints filed against your organization within the last 12 months.	
14. Have you submitted any findings of discrimination issued by a court or administrative agency to **both** the DCF Office of Civil Rights and appropriate external agency (DOJ, USDA). If NO, please explain.	☐ Yes ☐ No ☐ NA
15. Are program eligibility requirements applied to applicants and clients without regard to race, color, national origin, sex, age, marital status, religion, political affiliation, or disability? If NO or NA, please explain.	☐ Yes ☐ No ☐ NA
16. Are benefits, services, and facilities available to applicants and participants in an equally effective manner regardless of race, color, national origin, sex, age, marital status, religion, political affiliation, or disability? If NO or NA, please explain.	☐ Yes ☐ No ☐ NA
17. Are room assignments for in-patient services made without regard to race, color, national origin, sex, age, marital status, religion, political affiliation, or disability? If NO or NA, please explain.	☐ Yes ☐ No ☐ NA
18. Are auxiliary aids available to assure accessibility of services to hearing and sight impaired individuals? If NO, please explain.	☐ Yes ☐ No ☐ NA
19. Are the programs/facilities/services accessible to mobility, deaf or hard of hearing, and sight impaired individuals? If NO or NA, please explain.	☐ Yes ☐ No ☐ NA
20. Are Limited-English Proficient (LEP) applicants and recipients provided equal access to benefits and services, including free interpreter services? If NO or NA, please explain. List below what steps are taken to ensure meaningful access to persons with LEP (written policy, outreach, etc.).	☐ Yes ☐ No ☐ NA
21. Have you conducted a self-evaluation to identify barriers to serving individuals with disabilities or LEP? If NO or NA, please explain.	☐ Yes ☐ No ☐ NA
22. Provide the name and contact information for the individual designated as your organization's Section 504, ADA, and/or Title VI Coordinator for compliance activities.	
23. Are you providing Civil Rights training (employment and service delivery) for staff? If YES, how often? If NO or NA, please explain. List all the civil rights training provided to staff within the last 12 months.	☐ Yes ☐ No ☐ NA
24. If you conduct religious activities as part of your program or services, do you: a. Provide services to everyone regardless of religion or religious belief? b. Keep religious activity such as prayer and religious instruction separate from federally funded activities? c. Are religious activities voluntary? If NO or NA to any of the questions above, please explain.	☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA

25. If you are a sub-recipient of *DOJ funding and operate an educational program or activity*, have you taken the following actions: a. Adopted grievance procedures that provide for prompt and equitable resolution of complaints that allege sex discrimination in violation of Title IX of the Education Amendments of 1972? b. Designated a person to coordinate compliance with Title IX? c. Notified applicants, employees, students, parents, and clients that you do not discriminate on the basis of sex in your educational programs or activities? If applicable and you answered NO to any of the questions above, please explain.	☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA
26. If applicable, do you have an Equal Employment Opportunity Plan (EEOP)? If you are a sub-recipient of DOJ funding, have you filed the appropriate EEOP certification with Office of Civil Rights, Office of Justice Programs? **If YES, provide a copy of the EEOP and/or certification.**	☐ Yes ☐ No ☐ NA

PART IV.

DEPARTMENT OF CHILDREN AND FAMILIES USE ONLY			
Date Received by DCF Contract Manager			Date Reviewed by Contract Manager
Contract Manager Name/Signature			Telephone Number
Is the contract information (contract number, amount of contract, etc.) correct?			☐ YES ☐ NO
Did contracted services provider answer/complete all three sections? If YES, submit to Civil Rights Officer (CRO). If NO, return to provider for completion.			☐ YES ☐ NO
Date Submitted to Civil Rights Officer (CRO)	Date Received by CRO	Date Reviewed by CRO	In Compliance? ☐ YES ☐ NO
Comments			
Type of Compliance Review: ☐ On-Site Limited Review ☐ On-Site Full Review ☐ Desk Limited Review			
Date of Compliance/No-Compliance Notice	Response Due Date		Response Received Date
Compliant? ☐ YES ☐ NO	Civil Rights Officer Name/Signature		

Attachment 7

Mandatory Assurances
Form PR003-04

Please check Yes (Y) or No (N) as applicable for each item.	**Y**	**N**
1. History in the community. The Applicant has a minimum of three (3) years experience providing services in the community.		
2. The organization is not-for-profit		
3. Infrastructure: The Applicant possesses equipment and Internet access necessary to participate fully in this solicitation.		
4. Site Visit(s): The Applicant agrees to participate in the Site Visit on the days scheduled by BBHC.		
5. Non-discrimination: The Applicant agrees no person will, on the basis of race, color, national origin, creed or religion be excluded from participation in, be refused the benefits of, or be otherwise subjected to discrimination pursuant to the laws, rules and regulations which may regulate the funds paid and received by the Applicant pursuant to a contract issued hereunder, by the requirements of (a) Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended which prohibits discrimination in employment or any program or activity that receives or benefits from federal financial assistance on the basis of handicaps; (d) Age Discrimination Act 1975, as amended which prohibits discrimination on the basis of age, (e) Equal Employment Opportunity Program (EEOP) must meet the requirements of 28 CFR 42.301.		
6. Lobbying: The Applicant is prohibited by Title 31, USC, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," from using Federal funds for lobbying the Executive or Legislative Branches of the federal government in connection with a specific grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal funds if grants and/or cooperative agreements exceed $100,000 in total costs (45 CFR Part 93).		
7. Drug-Free Workplace Requirements: The Applicant does or will, provide a drug-free workplace in accordance with 45 CFR Part 76.		
8. Smoke-Free Workplace Requirements: Public Law 103-227, Part C-Environmental		

Attachment 7

Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library projects to children under the age of 18, if the projects are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's projects provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.		
9. Electronic Health Record: The Applicant certifies it has a fully operational Electronic Health Record system or will be fully operational and compliant with the requirements of the Department of Children and Families Pamphlet 155-2 (PAM 155-2) prior to the start date of any awarded contract by BBHC.		
10. Confidentiality & HIPAA: The Applicant certifies it shall be compliant with confidentiality and HIPAA requirements as required by applicable laws, rules, regulations and policies including but not limited to, the Health Insurance Portability Act of 1996 (HIPAA), FS 397 and CFR 42 Part 2.		
11. Certification of Non-supplanting: The Applicant certifies funds awarded under any BBHC solicitation and contract will not be used for programs currently being paid for by another source.		

By signing and submitting this Agreement, the Applicant certifies it will continually comply with each of the above requirements.

_____

Applicant Representative Printed Name

_____

Applicant Representative Signature

_____

Date

CLAS Plan Information (Attachment 8)

Broward Behavioral Health Coalition, as part of the OCP3 system of care initiative, requires all its network providers to comply with the National Standards for **Culturally and Linguistically Appropriate Services** in Health and Health Care (CLAS Standards). The CLAS Standards are utilized as the benchmark for evaluation because they are aligned with the U.S. Department of Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2010) and the National Stakeholder Strategy for Achieving Health Equity (National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity by providing clear plans and strategies to guide efforts to improve cultural and linguistic competence.

The CLC assessment tool was created using the CLAS Standards as benchmarks. This tool can serve as a guide for agencies to improve their CLC plans and better serve their target populations.

The tool includes the 4 themes that the CLAS Standards focus on: 1) Introduction: Principal Standard; 2) Governance, Leadership, and Workforce; 3) Communication and Language Assistance; and 4) Engagement, Continuous Improvement, and Accountability. Researchers decided to add two additional themes: 5) Family Involvement and 6) Service Delivery: Intake, Treatment, and Discharge. The family involvement theme centers around taking an individual approach to service delivery and values the importance of the family during treatment and discharge. The CLC plan should include several statements on how the agency values the individual and their familial preferences. Lastly, the service delivery theme centers on how the cultural and spiritual preferences of the individual are recognized during intake, service, and discharge. These two themes are an integral part of culturally appropriate practices to care that go beyond linguistically appropriate practices that is covered in CLAS standards 1-15.

BBHC will require providers to submit a CLC Action Plan based on the Assessment tool. Updates to CLC plans must be submitted annually and as needed thereafter for Contract Negotiations.

CLC Assessment Tool

Theme 1: Introduction: Principal Standard (Goal of the CLC Plan)

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 1: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	The plan states that the organization offers effective quality care responsive to diverse cultural and health beliefs and practices.				
	The plan states that the organization offers understandable quality care responsive to diverse cultural and health beliefs and practices.				
	The plan states that the organization offers respectful quality care responsive to diverse cultural and health beliefs and practices.				
	The plan states how the organization collects and recognizes cultural health beliefs.				
	The plan states that the care provided will be provided in the client's preferred language, recognizing their health literacy and other communication needs.				
	The plan acknowledges health literacy and other communication needs, and defines what those are or may be for the organization.				

Theme 2: Governance, Leadership, and Workforce

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	The plan states that the organization annually allocates resources to meeting the diverse cultural and linguistic needs of its clients.				
	The plan revisits its policies and management strategies on an annual basis to determine needs that may need addressing or added.				
	The plan states how often that the CEO and Board meets to set goals to improve diversity and offer continual cultural competence care and training as a part of the strategic plan.				
	The plan details how and when staff members can provide feedback on interactions with LEP and minority populations, to improve interactions and services.				
CLAS Standard 3: Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	The plan has protocols in place for recruiting diverse staff members including leadership and governance positions.				
	The plan specifies how organizations place priority on hiring members of staff with added bilingual or multilingual qualifications.				
	The plan specifies how the organization will recruit staff members that represent the service population, which includes advertising job opportunities in foreign languages in various outlets (social media networks, publications, professional organizations' email listservs, job boards, local schools, faith based organizations, training programs, minority health fairs, etc.).				
	The plan states that the organization recognizes staff who continue to meet the diverse needs of clients by offering the individuals internal promotions and other opportunities for upward mobility before seeking external candidates.				
	The plan states that the organization recognizes the diverse cultural beliefs of its employees.				
CLAS Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	The plan discusses how staff (workforce, leadership and governance positions) are trained on cultural norms, and how they vary by family (such as youth alcohol consumption or physical punishment).				
	The plan states that the organization supports the staff development of its employees, and how it places value on continued education and training in diversity and leadership.				
	The plan states how often staff and leaders receive training.				
	The plan states that the staff is trained on recognizing and responding to cultural health beliefs.				
	The plan states how both internal and external resources are used to educate the governance, leadership, and workforce on cultural beliefs that they may encounter.				
	The plan states that cultural competence in incorporated into staff evaluations and performance reviews.				
	The plan states what is included in the staff training, and how the training is evaluated.				

Theme 3: Communication and Language Assistance

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	The plan states that the organization offers language assistance to LEP individuals and/or other communication needs at no cost to the client.				
	The plan details the way that clients are made aware of no cost language assistance.				
	The plan states that the organization offers language assistance to LEP individuals and/or other communication needs for access to services in a timely manner.				
	The plan states how program directors, "point of contact staff" or agency's appointed "gatekeeper" are made aware of and trained in language assistance services, policies, and procedures.				
	The plan identifies how language needs are noted in records for individuals seeking care (which may include language needs, "I speak" cards, etc.).				
	The plan states the maximum time that it will take to provide an interpreter and the maximum amount of time for service delivery using a certified interpreter.				
CLAS Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	The plan states that the organization has the availability of language assistance services clearly displayed.				
	The plan states what language assistance services are available at all times.				
	The plan states how the organization translates appropriate material.				
	The plan states that there is a protocol for verbally informing clients of the availability of services in their preferred language.				
CLAS Standard 7: Ensure competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors should be avoided.	The plan states the protocol for ensuring language assistance providers are certified.				
	The plan states how the organization ensures interpreter competence, including the interpreter's active listening skills, message conversion skills, and clear and understandable speech delivery.				
	The plan states if community brokers are used within the organization.				
	The plan states that untrained individuals and minors should NOT be used as interpreters.				
CLAS Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	The plan states that the organization has clear, easy to understand multimedia materials and signage in the languages used within the service community.				
	The plan states what multimedia materials are available in various languages.				
	The plan states that there is a formalized process and what the process is for translating materials into languages when the materials are not readily available.				
	The plan notes that the materials have been tested with members of the target audience (such as through focus groups, where members may identify content that may be embarrassing or offensive, suggest cultural practices that may be more appropriate examples, and assess whether the graphics are appropriate and reflect the diversity of the community).				
	The plan states that easily understandable signage is posted throughout the service area (including, but not limited to diverse languages, minority representation, and responsive to LGBTQ+ (safe space sign), and youth populations).				

Theme 4: Engagement, Continuous Improvement, and Accountability

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 9: Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	The plan states that the organization will regularly review organizational planning and operations with the purpose of identifying cultural and linguistic needs that are not being met.				
	The plan states how the annual organizational diversity goals will be created and discussed in meetings throughout the year.				
	The plan states that cultural and linguistic goals created by the organization will be included in the strategic plan, and will regularly be included as agenda items in staff meetings.				
CLAS Standard 10: Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and CQI activities.	The plan ensures that there is an ongoing evaluation of CLAS standards and how they are implemented within the organization.				
	The plan states that all staff are provided with CLAS-oriented feedback in their performance reviews.				
	The plan states how often CLAS standards are evaluated and revisited for quality improvement.				
CLAS Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	The plan details how and when demographic data will be obtained from the target community, and where the information will be updated and posted within the organization.				
	The plan discusses how the community demographic data will be used in program planning and service delivery.				
	The plan discusses how the community demographic data will be used to guide translated material and signage in the organization.				
	The plan discusses how the community demographic data will highlight any apparent disparities that may exist.				
	The plan states that the community demographic data and disparities will be presented to the governance and leadership of the organization annually.				
CLAS Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	The plan details how and when community health assets and needs are performed.				
	The plan will discuss when and if qualitative data will be collected and used (such as focus groups or interviews) to enhance the community health assets and needs.				
	The plan discusses how findings from the community health needs assessments are utilized within the organization.				
	The plan offers opportunities for collaboration with other community based partners and stakeholders in discussing assets and challenges of the community and sharing best practices related to: 1) meeting needs; 2) capturing community demographics; and 3) strategies on the dissemination of findings.				
	The plan discusses how findings from the community health needs assessments are used in program development.				
CLAS Standard 13: Partner with the community to design, implement, and evaluate policies, practices, and services to	The plan details the method of targeting and communicating with other community based organizations that offer services that clients would benefit from.				
	The plan recognizes the success of cross-system collaborative efforts and the use of multidisciplinary teams in working with children and families.				

ensure cultural and linguistic appropriateness.	The plan states the organization's policies on ensuring collaborative agencies practice culturally and linguistically appropriate services and adhere to the CLAS standards.			
CLAS Standard 14: Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	The plan states the organization's strategies for LEP and others with communication needs to fill out conflict and/or grievances with the organization.			
	The plan offers conflict and grievance forms in various languages, including all of the languages that are represented within the target community.			
	The plan details the grievance resolution process, and the maximum length of time that grievances will be addressed.			
CLAS Standard 15: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.	The plan details where the organization's diversity and linguistic policies are posted for the public.			
	The plan specifies that information collected from stakeholders is used in training, meetings, and for quality improvement.			
	The plan states the organization's policies on open communication to raise concerns of cultural and linguistic needs.			
	The plan states the protocol for a clear communication plan that is discussed with the individual seeking behavioral health care services and their family during discharge.			

Suggested Themes 5 and 6

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
Family Acknowledgement	The plan states the organization's policy for including family in the service delivery, including the treatment and discharge of the client.				
	The plan details the organization's efforts and strategies towards coordinated, individualized, family-driven and youth guided services.				
	The plan should detail how the organization identifies familial preferences for and availability of traditional healers, religious and spiritual resources, alternative or complementary healing practices, natural supports, bilingual services, self-help groups, and consultation from culturally and linguistically competent independent providers, except when clinically or culturally contraindicated.				
	The plan acknowledges that treatment plans do not always match family values, and that improved listening to family and youth is suggested.				
Spiritual and Cultural Beliefs in Treatment & Discharge	The plan states that cultural and spiritual beliefs are recognized during the intake assessment.				
	The plan states that cultural and spiritual beliefs are recognized during the service treatment.				
	The plan states that cultural and spiritual beliefs are recognized during discharge of the individual.				
	The plan recognizes that traditional and natural supports may be necessary for treatment and interactions with individuals seeking behavioral health care.				

CLAS STANDARDS SOURCE: https://www.thinkculturalhealth.hhs.gov/

PROGRAM DESCRIPTION

The program description is NOT required for contracts that are solely for the purposes of Prevention Partnership Grants, FACT, or Title XXI services.

The service provider shall submit the proposed Program Description to the department or Managing Entity, as applicable, for approval prior to the start of the contract or subcontract period. Once a contract or subcontract has been signed, the service provider shall submit a final version of the Program Description.

Table 1 - ORGANIZATIONAL PROFILE	
Organization Name	
Subdivision or Department Administering Services (if applicable)	
Organization Address	
Phone Number	
Federal ID Number	
National Provider Identifier	
Board President/Chairperson	
Chief Executive Officer	
Chief Operating Officer	
Chief Financial Officer	
Data Security Officer	
Annual Operating Budget *(Include all revenue sources)*	
Number of employees	
Geographic area(s) served	
Accreditations	
Major Funders	
Year of Incorporation	
Corporate Mission Statement	
Summary Description of Organization's Services	

Please attach an Organizational Chart showing major operational and administrative units.

Please attach documentation of Not-for-profit status.

Table 2 Projected Numbers Served			
Target Population	**Annual Number Contract Funded**	**Annual Number Other Funded**	**Total Annual Number Served**
Mental Health			
Adults with Severe & Persistent Mental Illness			
Adults with Serious & Acute Episodes of Mental Illness			
Adults with Mental Health Problems			
Adults with Forensic Involvement			
Children with Serious Emotional Disturbance			
Children with Emotional Disturbance			
Children at Risk of Emotional Disturbance			
Other Populations to be Served *(specify)*			
Substance Abuse			
Adults with Substance Abuse			
Children with Substance Abuse			
Other Populations to be Served *(specify)*			
Non-Client Services			
Insert description of services here			

Table 3 - Proposed Performance Measures		
Check If applicable	**Measure Number**	**Measure Description**
☐	MH003	Average annual days worked for pay for adults with severe and persistent mental illness
☐	MH703	Percent of adults with serious mental illness who are competitively employed
☐	MH742	Percent of adults with severe and persistent mental illnesses who live in stable housing environment
☐	MH743	Percent of adults in forensic involvement who live in stable housing environment
☐	MH744	Percent of adults in mental health crisis who live in stable housing environment
☐	SA753	Percentage change in clients who are employed from admission to discharge
☐	SA754	Percent change in the number of adults arrested 30 days prior to admission versus 30 days prior to discharge
☐	SA755	Percent of adults who successfully complete substance abuse treatment services
☐	SA756	Percent of adults with substance abuse who live in a stable housing environment at the time of discharge
☐	MH012	Percent of school days seriously emotionally disturbed (SED) children attended
☐	MH377	Percent of children with emotional disturbances (ED) who improve their level of functioning
☐	MH378	Percent of children with serious emotional disturbances (SED) who improve their level of functioning
☐	MH778	Percent of children with emotional disturbance (ED) who live in a stable housing environment
☐	MH779	Percent of children with serious emotional disturbance (SED) who live in a stable housing environment
☐	MH780	Percent of children at risk of emotional disturbance (ED) who live in a stable housing environment
☐	SA725	Percent of children who successfully complete substance abuse treatment services
☐	SA751	Percent change in the number of children arrested 30 days prior to admission versus 30 days prior to discharge
☐	SA752	Percent of children with substance abuse who live in a stable housing environment at the time of discharge

Table 3 - Proposed Performance Measures		
Check If applicable	**Measure Number**	**Measure Description**
Proposed additional outcome measures *Provide measure description, measure methodology and measure target*		

Table 4 - Funding Requested			
State Fiscal Year	**Contract Amount**	**Local Match Amount**	
	$	**$**	
	$	**$**	
	$	**$**	
Total	**$**	**$**	
Special Funding Considerations *Check if applicable*			
☐	TANF	☐	SAPTBG Set Aside for Women
☐	PATH	☐	SAPTBG Prevention Set Aside
☐	Title XXI	☐	SAPTBG HIV Set Aside
☐	Indigent Drug Program	☐	Purchase of Therapeutic Services
☐	Other Grant Source *(Describe)*	☐	Other Funding Consideration (Describe)

PROGRAM DESCRIPTION

Service Delivery Sites

Complete this table for <u>each</u> location at which services funded by this contract or subcontract will be provided. Add rows or tables as needed.

Location Information	
Location Name	
Address	
Contact Person (Name and Title)	
Phone #	
Email	

Program Type MH or SA	**Client or Non Client**	**Program Name**	**Days and Hours of Operation**	**Target Population(s) Served**	**Facility Licenses** *(Attach a copy of all applicable licenses)*

Full Time Equivalent (FTE) Service Staffing Levels

Covered Service	**Supervisory**	**Direct Service**	**Support**	**Total FTE's**
Totals				

PROGRAM DESCRIPTION
Service Delivery Strategies and Approaches

Identification and Engagement Strategies

Identify the major referral sources for each target population:

1. General SAMH Target Population(s) Served:
2. Special Populations, if applicable:
    - **2.1.** Children at risk of residential services or juvenile justice involvement
    - **2.2.** Pregnant/Post-partum Women
    - **2.3.** Individuals Involved with the Forensic or Criminal Justice System
    - **2.4.** Individuals with co-occurring disorders
    - **2.5.** Individuals with HIV
    - **2.6.** Others: (describe)

Describe the organization's specific individual identification and engagement strategies applicable to the array of covered services provided. Highlight any use of science-based or evidence-based approaches.

Specify the nature and role of Incidental funding and any categorical funding applicable used in support of individual identification and engagement.

Describe the source, use and amount of matching funds to support these strategies.

Service Delivery Strategies

Describe the organization's specific service delivery strategies for providing individual services/care. Service delivery strategy descriptions should separately address those strategies as applied to the general SAMH target populations served and any special population groups. This description should address:

1. The specific services that will be provided within each covered service;
2. The means by which individual and family needs will be evaluated and re-evaluated throughout the episode of care;
3. The processes employed to match individuals and families to services and ensure that services are consistent with the individuals' and families' individual recovery and resiliency needs;
4. Any science-based or evidence-based models employed or practices utilized;
5. The service capacity proposed for funding;
6. Admission and discharge criteria;
7. Average length of participation for persons served; and
8. The use of Incidental funds.

Integration of Recovery and Resiliency Concepts

Describe the steps that the organization will take to integrate recovery and resiliency into service provision. Discuss how the organization promotes individual and family living, working, learning and socializing. Discuss how the organization will employ person-centered language.

Individual and Family Participation Strategies

Discuss how the organization promotes family participation in services and practices for the development of natural supports. Discus how the organization involves individuals and families in the planning, development, implementation and evaluation of service delivery systems.

Continuing Care Strategies

Identify the major continuing care strategies for individuals and families completing services. Address placement and referral activities specific to the general SAMH target populations served and any Special Populations. This description should address:

1. The processes by which individuals and families are prepared for and transitioned to continuing care services,

2. The major continuing care strategies, best practice models, and community housing/living options alternatives for individuals and families completing services in this Activity (within the organization and within the community system of care),

3. A description of any Activity funded cost centers and related services utilized to affect the transition, and

4. How Incidental funds and any applicable, restricted funding are used to support individual transitions.

Individual Completing the Document:

Name: _____

Title: _____

Phone: _____ **Fax:** _____

E-mail Address: _____

Submitted by:

_____

Provider Representative Signature Date

Approved by:

_____

Department or Managing Entity Representative Signature Date

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

Name of Entity D/B/A	CLIA No.	EIN	Telephone No and Fax No.
Street Address	**City, County, State**		**Zip Code**

II. Answer the following questions by checking "Yes" or "No". If any of the question answered are "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest in the reporting entity that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, of XX?

☐ Yes ☐ No LB 2

B. Are there any directors, officers, agents, or managing employees of the reporting entity who have convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, XX?

☐ Yes ☐ No LB 3

C. Are there any individuals currently employed by the reporting entity in a managerial, accounting, auditing, or similar capacity who were employed by the reporting entity's fiscal intermediary or carrier within the previous 12 months?
(Title XVIII providers only)

☐ Yes ☐ No LB 4

III. (a) List names, addresses for individuals, or the EIM for organizations having direct or indirect ownership or a controlling interest in the entity. List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, they must be reported under Remarks.

Name	Address	EIN	LB 5

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation LB 6
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid and/or CLIA facilities? (Example: sole proprietorship, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers and/or CLIA numbers.

☐ Yes ☐ No LB 7

Name	Address	Provider Number/CLIA Number

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

IV. (a) Has there been a change in ownership or control within the last year? ☐ Yes ☐ No LB 8
If yes, give date _____

(b) Do you anticipate any changes of ownership or control within the year? ☐ Yes ☐ No LB 9
If yes, give date _____

(c) Do you anticipate filing for bankruptcy within the year? ☐ Yes ☐ No LB 10
If yes, give date _____

V. Is this facility operated by a management company or leased in whole or part by another organization?
If yes, give date _____ ☐ Yes ☐ No LB 11

VI. Has there been a change in Director within the last year?
If yes, give date _____ ☐ Yes ☐ No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address or Corporation and EIN) ☐ Yes ☐ No LB 13
Name EIN#

Address LB 14

VII. (b) If the answer to Question VII. (a) is No, was the facility ever affiliated with a chain? ☐ Yes ☐ No LB 18
Name EIN#

Address LB 19

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILINT TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF AN APPLICATION FOR A CLIA CERTIFICATE OR SUSPENSION AND/OR REVOCATION OF AN EXISTING CLIA CERTIFICATE, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title
Signature	Date

Remarks