**Request for Qualifications #2019-BH01:**

**Therapeutic Foster Care Services**

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| **ATTACHMENT A - APPLICATION** | | | |
| **COUNTY OF SOLANO**  **Health & Social Services Department,**  **Behavioral Health Division** | | **REQUEST FOR QUALIFICATIONS** | **#2019-BH01** |
| **ISSUE DATE** | **March 29, 2019** |
| RFQ Coordinator: | James Johnson Jr. | Return your Application in a sealed envelope, clearly marked:  **Solano County Health & Social Services**  **c/o Research & Planning, MS 5-200**  **275 Beck Ave.**  **Fairfield, CA 94533**  Qualifications must be received no later than  **April 26, 2019, 5:00 PM PST**  Late Qualifications will not be accepted. | |
| E-mail Address: | [JJJohnson@SolanoCounty.com](mailto:JJJohnson@SolanoCounty.com) |
| Address: | Solano County Health & Social Services Department  c/o Research & Planning  MS 5-200  275 Beck Ave.`  Fairfield, CA 94533 |
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| **Application Instructions:** Applicants must fully complete this Application form (Attachment A), responding to every question, and attach all necessary requested documents. Applicants must fill in desired check boxes and adhere to page limits where indicated. | | | |

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| **Request for Qualifications #2019-BH01: Therapeutic Foster Care** |
| Applicant Organization: |
| Applicant Contact Name & Phone Number: |
| Applicant Address/City/State/Zip: |
| Form of Business:  For-profit  Non-profit  Government Agency  Other: |

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| The undersigned acknowledges that the County’s Standard Contract (Attachment C) has been reviewed and that, if awarded, all contract terms and conditions are accepted.  YES  NO  If NO, Qualifications to Funding Agreement (add additional pages as needed): | | | | | |
| The undersigned certifies and makes assurance of the Applicant’s compliance with:   * All requirements, terms, and conditions of RFQ#2019-BH01; * The [Laws of the County of Solano](https://www.codepublishing.com/CA/SolanoCounty/) * [Title VI of the federal Civil Rights Act of 1964](https://www.hhs.gov/civil-rights/for-individuals/special-topics/needy-families/civil-rights-requirements/index.html) * [Title IX of the federal Education Amendments Act of 1972](https://www.justice.gov/crt/overview-title-ix-education-amendments-1972-20-usc-1681-et-seq) * The [Equal Employment Opportunity Act](https://www.eeoc.gov/eeoc/history/35th/thelaw/eeo_1972.html) and the regulations issued thereunder by the federal government. * The [Americans with Disabilities Act](https://www.ada.gov/pubs/ada.htm) of 1990 and the regulations issued thereunder by the federal government. * All contract employees performing services and/or work as a result of this solicitation must have documented legal authority to work in the United States of America; * The condition that the submitted application was independently arrived at, without collusion, under penalty of perjury; and * The condition that no amount shall be paid directly or indirectly to an employee or official of First 5 Solano as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Applicant in connection with the Procurement under this RFP.   YES  NO A NO response shall disqualify this Application. | | | | | |
| **FAILURE TO SIGN THIS SECTION MAY DISQUALIFY YOUR RESPONSE** | | | | | |
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| ORGANIZATION | |  |  |  |  |
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| SIGNATURE | |  | DATED |  | FED EMPLOYER ID NO. |
|  | If signature is other than “Executive Director”, **evidence showing authority to bind the organization must be attached**. | | | | |
| PRINTED NAME |  | | | | |
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| TITLE |  | | | | |

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| **APPLICANT INFORMATION** | | | | | | |
| **A.** | **PERSON RESPONSIBLE FOR PREPARATION OF APPLICATION** | | | | | |
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|  | **CITY** | | | **STATE** | **ZIP CODE** | |
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|  | **PHONE NUMBER** | **FACSIMILE NUMBER** | | **CELL PHONE NUMBER (OPTIONAL)** | | |
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|  | **E-MAIL ADDRESS** | | | | | |
| **B.** | **SIGNATORY ON PAGE 1 (if different than 1.A. above)** | | | | | |
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|  | **NAME** | | **TITLE** | | | |
|  |  | | |  |  |  |
|  | **ADDRESS** | | | **FLOOR** | **SUITE** | **ROOM** |
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|  | **CITY** | | | **STATE** | **ZIP CODE** | |
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|  | **PHONE NUMBER** | **FACSIMILE NUMBER** | | **CELL PHONE NUMBER (OPTIONAL)** | | |
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|  | **E-MAIL ADDRESS** | | | | | |
| **C.** | **PERSON RESPONSIBLE FOR PROGRAM AND CONTRACT MANAGEMENT** | | | | | |
|  | Same as Section A above.  Same as Section B above. | | | | | |
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|  | **NAME** | | **TITLE** | | | |
|  |  | | |  |  |  |
|  | **ADDRESS** | | | **FLOOR** | **SUITE** | **ROOM** |
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|  | **CITY** | | | **STATE** | **ZIP CODE** | |
|  |  |  | |  | | |
|  | **PHONE NUMBER** | **FACSIMILE NUMBER** | | **CELL PHONE NUMBER (OPTIONAL)** | | |
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|  | **E-MAIL ADDRESS** | | | | | |

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| **SECTION 1:**  **APPLICANT QUALIFICATIONS** | |
| Describe the organization’s qualifications to provide Therapeutic Foster Care services as outlined below in **Sections 1A and 1B**. **(1-page maximum)** | |
| **1A** | Please discuss the agency’s licensure and accreditation qualifications established by the California Department of Social Services (CDSS); as well as its ability to approve Therapeutic Foster Care (TFC) homes and accept children/youth for placement from Solano County Child Welfare Services and/or Probation. |
| **1B** | Please discuss the agency’s ability to and history of Medi-Cal certification to provide Specialty Mental Health Services (SMHS) with a contract with a MHP as a Medi-Cal provider for **at least one-year**. |

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| **SECTION 2:**  **SCOPE OF SERVICES** | | |
| Describe the organizational capacity to provide the services outlined in **SECTIONS 2A-2E** below. Please answer each section separately (See Section 1.4 of RFQ**)**. **3-page maximum** | |
| **2A** | Please describe how you will recruit, train, approve, and supervise parents to meet both: Resource Family Approval (RFA) and TFC parent requirements. Make sure to include how you will provide or arrange for 40 hours of initial TFC Parent training, and an additional 24 hours of continued annual training for all parents. Finally, describe how you will ensure that TFC Parents meet California’s Medicaid rehabilitation provider qualification for “other qualified provider” (see [California State Medicaid Plan Attachment 3.1 A Rehabilitation Mental Health Services](https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement_3_to_Attachment_3.1-A.pdf)). |
| **2B** | Please discuss how your agency will collaborate with the CFT to identify supports for the child and family, including linking with a TFC Parent who can best meet the child or youth’s individual needs, and integrating the TFC Parent into the CFT. |
| **2C** | Please discuss your ability to employ a Licensed Mental Health Professional (LMHP) or a Waivered or Registered Mental Health Professional (WRMHP) who will provide supervision and intensive support to TFC parents. |
| **2D** | Please discuss the agency’s ability and strategy for tracking and reporting on the following:   * How many children/youth receiving TFC transition to a lower level of care, and how many require a higher level of care despite receiving TFC services? * How many CFT meetings are attended by both TFC Parents and TFC Agency staff? * Total number of children/youth who receive TFC and the length of stay for each. |

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| **SECTION 3:**  **SUPPLEMENTAL QUESTIONS** | | |
| Provide answers to the **Supplemental Questions 3A–3D** below. Please address each question individually. **(3-page maximum)** | |
| **3A** | Describe your agency’s experience as a Foster Family Agency delivering services to foster youth and their foster families. Provide details about your agency’s relationships with social service agencies, including mental health, child welfare, and juvenile probation. Include information about your agency’s philosophy about the role of foster families in the lives of children/youth in foster care. Also discuss your agency’s experience with recruiting and training foster parents. |
| **3B** | Describe how your agency’s goals and philosophy are aligned with the values and principles of the [*Integrated Core Practice Model for Children, Youth, and Families*](https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-022%20Integrated%20Core%20Practice%20Model%20and%20Integrated%20Training%20Guide/Integrated_Core_Practice_Model.pdf) *--* specifically with the TFC Service model. |
| **3C** | Describe your agency’s understanding of the primary presenting strengths and challenges for children/youth involved in the mental health, child welfare, and juvenile probation systems. |
| **3D** | Describe how your organization will ensure cultural and linguistically competent and sensitive service provision to a diverse population of children and families. Specifically address how you will serve underserved populations, such as the LGBTQ community, and provide services in Solano County’s required threshold language of Spanish. |

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|  | **SECTION 4:**  **BUDGET/BUDGET NARRATIVE** |
| **4A** | **Note:** *This Section is to be provided as a separate attachment, clasped separately, from the sequentially numbered pages of the rest of the Application.*  Provide a line item budget utilizing the format below. For staffing, indicate title of position, such as Program Director. For operating expenses, indicate actual expense, such as *Office Supplies*. Add rows as necessary.     |  |  |  |  |  | | --- | --- | --- | --- | --- | | Item | FTE | Behavioral Health Funds | Other Funds | Total Budget | | Personnel |  |  |  |  | | Operating Expenses |  |  |  |  | | Indirect Costs |  |  |  |  | | TFC Parent Payments |  |  |  |  | | Other (describe) |  |  |  |  | | **Total:** |  |  |  |  |  * **Staff Salaries:** For each staff position listed on the Budget Worksheet, explain how the salaries were determined and provide support for the stated salary. For example, state the classification and provide the salary range for the employee in the stated classification. Describe how each position will contribute to the activities outlined in the Program Narrative. * **Employee Benefits:** Explain what is included in the employee benefits costs and how were the costs determined. Provide support for the costs including a statement regarding percentage of salary or actual dollars used for employee benefits, including medical, retirement, taxes, etc. * **Operating Expenses:** For each proposed operational line item provide detail regarding exactly what expense will be captured under said line item and how the cost was arrived at. Describe how the cost will contribute to the activities outlined in the Program Narrative * **Indirect and Administrative Costs:** Describe what is included in the indirect cost rate and how it was determined. If the Indirect Cost Rate is over 10% of Salaries, Benefits, and Operating Expenses, please attach the organization’s Cost Allocation Plan.   **See SECTION 1.6 of RFQ for additional guidelines.** |

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| **4B** | Provide a budget narrative for your proposed budget. Include enough detail to inform reviewers of the need for the expenses requested. **2-page maximum**  Please address the following:   * Describe the proposed rate per youth, per day, for TFC services. * Describe the staffing pattern proposed to administer and monitor the TFC services. * Describe the fiscal and operational infrastructure and experience to support this program.   + Include the name and title of the individual responsible for cost control and how long the person has been in this position.   + Include the number of employees in leadership and the fiscal department, tenure of each employee, and any relevant information that supports the depth and breadth of the fiscal and operational infrastructure of the organization.   + Include a statement as to whether, in the last ten years, the applicant has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors; and if so, an explanation providing relevant details. |
| **4C** | Provide audited financial statements for the last two full years (including Management Letter(s) if issued); or if Applicant does not have audited financial statements, provide unaudited statements of revenue and expenditures (and balance sheet if applicable), or Form 990, and explain why the Applicant has no audited financial statements. |